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 waivers 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:

This renewal application is proposing to:

Update Appendix A-7 to reflect current practice.

Appendix D 1d - add statement - The ISP is distributed to the individual and other people involved in the implementation of the plan. to be consistent with #0117 and #0375 renewals.

Appendix J -

Update to reflect current projections.

Other items:
Update QIS and performance measures to be consistent with other ODDS 1915 (c) waivers and based on CMS feedback.

Remove all asterisks from previous amendments.

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*):

Medically Fragile (Hospital) Model

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**

Original Base Waiver Number: OR.40193
Draft ID: OR.005.05.00

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

Model Waiver

E. Proposed Effective Date: (mm/dd/yy)

07/01/24

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 in42 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 Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR**

§440.150)

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

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:

Oregon's approved 1915(b)(4) waiver- "Office of Developmental Disabilities Services Selective Contracting 1915(b)(4) Waiver - Waiver Case Management #OR.10". Oregon limits the choice of qualified providers of Waiver Case Management services to employees of Community Developmental Disability Programs and the Office of Developmental Disabilities Services.

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:

H. Dual Eligiblity 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

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:
To serve children with significant medical needs who meet a score of 45 on the Medically Fragile Children's Unit (MFCU) Clinical Criteria assessment checklist.

Objectives: This waiver will serve children, from birth through age 17, who meet the Hospital level of care. These children, due to their medical needs, require the specialized services provided through this HCBS waiver and the Medicaid State Plan in order to remain in or return to the family home. The critical goal of this waiver is to assure that children who have significant medical needs 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:
Organizational Structure:
The Oregon Health Authority(hereinafter referred to as OHA) is the Single State Medicaid/CHIP agency (SSMA) responsible for the administration of programs funded by Medicaid and CHIP in Oregon. The Oregon Department of Human Services (hereinafter referred to as ODHS or the Department) is the Operating Agency responsible for the operation of certain programs under Medicaid, including home and community-based waivers.

OHA and ODHS, by written interagency agreement (IAA), have defined the working relationship between the two agencies and outlined the OHA delegation of authority to ODHS for day to day operation of waiver programs.

ODHS provides leadership, regulates services, provides protective services, manages resources, and carries out Oregon's operational responsibilities related to Medicaid program participation in long-term care for individuals who have Developmental Disabilities/Intellectual Disabilities (DD/ID), are elderly, or who are adults with physical disabilities.

Service Delivery Methods:
ODHS contracts directly with the qualified providers chosen by the individuals and families through the family/person-centered planning process. ODHS staff will oversee the determination of level of care, service plan development, qualified providers and assist individuals and families to choose their services providers. Providers may choose to contract directly with OHA as the single state agency.

3. Components of the Waiver Request

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

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. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness 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 statewideness 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

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

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/IID.

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:

Opportunities for public input on service performance and continuing needs are not limited to this waiver amendment process. Self-advocates, families, provider organizations and community leaders were instrumental in developing an original vision of community-based alternatives to institutional care that led to creation of Oregon's waiver service system in the 1980s and continue to partner with the State to improve and enhance community-based services to individuals who are aged or have physical, intellectual or developmental disabilities. Consumer-based advisory groups are longstanding partners, as are groups representing providers and local governments, in revisiting the vision and establishing parameters for services. Several service developments and corresponding waiver amendments have had their roots in this public input over a long history with waiver services.

Standing committees such as the Oregon Developmental Disability Council, Oregon Rehabilitation Association and Community Providers Association of Oregon meet regularly to provide comment and input to the Department on quality, reimbursement, and issues that directly affect the population served under the waiver. These committees consist of members the public, including recipients, advocates and service providers.

The Home Care Commission is a quasi-governmental agency that meets regularly with recipients, advocates and providers and provides input to the Department on issues that affect recipients of in-home services. Recommendations made by these committees are utilized during development and implementation of any changes to the waiver and services provided to waiver recipients.

Oregon Tribes are notified and provided adequate time to provide input in accordance with Presidential Executive Order 13175. Tribes are notified according to Oregon's approved Medicaid State Plan.

Public notices are sent electronically to:

The ODDS Compass Project web page, waiver section: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/DD/Pages/compass-project.aspx

The ODHS news release page: https://www.oregon.gov/dhs/dhsnews/Pages/news-releases.aspx

FlashAlert service: a service the state subscribes to, www.flashnews.net. FlashAlert® collects emergency messages and news releases from 1,760 organizations in the Portland/Salem/SW Washington area and provides it to the news media via a continuously updated website and e-mails. It automatically places this information into the websites of participating stations and newspapers. It sends our press releases to several hundred news media sites throughout Oregon.

Social media: public notices are posted on the ODDS Facebook page and Twitter.

Public input is requested during this electronic process, as well as non-electronically during meetings with program staff and stakeholders prior to submission of any waivers or waiver amendments. CDDPs and Brokerages were also asked to address the non-electronic format by posting the attached public notice in their offices and having a copy of the waiver, also attached, available for people upon request.

Public notice is provided prior to the effective date of substantive changes. Public input is gathered on an ongoing basis, and at least 30 days prior to submission of the waiver application. Public input is summarized and submitted to ODDS leadership and program staff. ODDS leadership and staff review the requests for waiver revisions and determine the feasibility of making the suggested changes. The decision to make revisions to the waiver application is made by ODDS leadership with input from program staff. OHA, the State Medicaid Agency, reviews and approves all revisions to the waiver application prior to submission.

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)

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

Last Name: Levy

First Name: Vivian

Title: Interim State Medicaid Director

Agency: Oregon Health Authority

Address: 500 Summer Street NE

Address 2:

City: Salem

State: **Oregon**

Zip: 97301-1076

Phone: (503) 519-3512 **Ext:** ☐ **TTY**

Fax: (503) 945-5872

E-mail: vivian.Levy@oha.oregon.gov

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

Last Name: Lansky

First Name: Anna

Title: Interim Director - Office of Developmental Disabilities Services

Agency: Oregon Department of Human Services

Address: 500 Summer Street NE

Address 2:

City: Salem

State: **Oregon**

Zip: 97301-1064

Phone: (503) 507-3196 **Ext:** ☐ **TTY**

Fax: (503) 373-7823

E-mail: Anna.s.lansky@odhs.oregon.gov

8. Authorizing Signature

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.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Levy

First Name: Vivian

Title: Interim Medicaid Director

Agency: Oregon Health Authority

Address: 500 Summer Street NE

Address 2:

City: Salem

State: **Oregon**

Zip: 97301

Phone: (503) 519-3512 **Ext:** ☐ **TTY**

Fax: (503) 945-5872

E-mail: vivian.Levy@oha.oregon.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter

"Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix I-2a rate information for employment services

Rates guidelines for all waiver services are established and published by the Department. Costs of services are estimated based upon ODHS-published allowable rates and other limitations imposed by Oregon Administrative Rule. Rates must comply with Oregon's minimum wage standards.

Wages for Personal Support Workers are established in the Collective Bargaining Agreement (CBA). Adjustments to wages are legislatively approved and negotiated through the CBA process. CBAs are negotiated biennially. The Department applies cost of living adjustments as required by legislative mandates or other CBA. The rates do not include employee benefits, room and board administrative costs, or other indirect costs.

For Employment Path Services and Small Group Employment Support ODHS established payment rates for provider organizations, based on stakeholder input, market costs, and other requirements imposed by Oregon Administrative Rule (OAR). Additional information included a comparison of workers in comparable fields, based on Bureau of Labor Statistics.

Provider organization rates for Employment Path Services and Small Group Employment Support, are based on an hourly billing units. The reimbursable hourly rates are tied to funding categories with higher rates paid for the delivery of services to individuals with more significant needs. Individuals are assigned one of four funding categories based on the functional needs assessment that measures a person’s support needs, as well as any exceptional medical or behavioral support needs.

For payment rates for provider organizations of Individual Employment Support Job Coaching, Job Development and Discovery/Career Exploration Services, ODHS contracted with Burns and Associates, to conduct a comprehensive rate study. The rate study encompassed several activities, including:

Policy goals that could affect the rates were identified. These goals included supporting the State’s Employment First objectives and assisting individuals with more significant needs to access employment.
• A provider advisory group was convened several times during the rate-setting process to serve as a ‘sounding board’ to discuss project goals and materials.
• All providers were invited to complete a survey related to their service design and costs.
• Benchmark data was identified and researched, including the Bureau of Labor Statistics’ cross-industry wage and benefit data.
• Proposed rate models that outline the specific assumptions related to each category of costs were developed and posted online.
Providers and other stakeholders were notified of the posting via email. A dedicated email address was created to accept comments and suggestions for a period of approximately one month. B&A and ODDS reviewed every comment submitted and prepared a written document summarizing its response to each, including any resulting revision to the rate models or an explanation for why no change was made.

Based on the rate study, B&A developed independent rate models intended to reflect the costs that providers face in delivering a given service. Specific assumptions are made for these various costs, including:
• The wage of the direct care provider
• Benefits for the direct care provider
• The productivity of the direct care provider (to account for non-billable responsibilities)
• Other direct care costs, such as transportation and program supplies
• Agency overhead costs
• Programmatic factors that impact per-person costs, such as staffing ratios

The Individual Employment Support Job Coaching rate models create an outcome-based payment model wherein provider organizations rates are reimbursed based on the hours the supported individual works. This incentivizes providers to maximize the number of hours that an individual works while simultaneously encouraging the fading of provider supports and the transition of individuals to workplace supports. Thus, in addition to the cost-based elements described above, a key assumption in the rate models is the anticipated ratio of direct job coaching hours to the hours that an individual works. These ratios vary based upon individual need and length of time on the job (employment phase).

First, the Job Coaching rates are differentiated based upon individuals’ level of need. There are higher rates for individuals with more significant needs due to a higher ratio of support hours to work hours and
the need for more indirect support. There will be four payment categories for Job Coaching services. However, given the small number of individuals in the higher categories of need and the need to mitigate the influence of outliers, categories three and four will be combined for the purpose of calculating the ratios (meaning that the rates for rate categories 3 and 4 will be the same). Individuals are assigned to one of the four rate categories based on the functional needs assessment that measures a person’s support needs as well as any exceptional medical or behavioral support needs.

Second, Job Coaching rates vary based on the number of months the individual remains in the job, recognizing that the need for provider support should decline over time as individuals transition to workplace supports. There are three employment phases: Initial, Ongoing, and Maintenance. Initial rates are highest and are effective for the first six months of employment. Ongoing rates apply to the next 18 months. Maintenance rates are lowest and apply after 24 months of employment, if the individual's planning team determines that ongoing supports are needed.

In order to balance the need for rate stability so that providers are willing to plan and invest in their programs with the requirement that payment rates be consistent with efficiency, economy, and quality of care as well as sufficient to ensure an adequate supply of providers, the assumed ratios of direct job coaching hours to individuals' work hours will be periodically reviewed. These ratios were reviewed in 2018 with accompanying changes to rates occurring in 2019.

The next review of the support hour ratios in the Job Coaching rate models will occur in 2020 with any changes implemented in 2021 and will rely on data from the previous two years. Thereafter, the ratios will be reviewed every five years. To ensure the integrity of the process, the review will rely upon data from the five previous years.

The 2020 review occurred, and rate increases were implemented based on the review results. The next review will occur in 2025 with any changes implemented in 2026.

These ratios will be reviewed using data from Oregon's billing system, eXPRS.

To bill job coaching through Oregon's billing system (Plan of Care) a provider must enter the hours the individual works as well as the hours of direct support. Record of this must be maintained by the provider in the form of timesheets, paystubs, and progress notes. In any year in which the assumed ratios will be reviewed and rebased as needed, ODDS will extract data on or around September 1. For each rate model (that is, each rate category for each employment phase), the average support hour to work hour ratio will be calculated and rounded up to the nearest ten percent. If these ratios differ from those assumed in any of the rate models, the models will be updated with the new rates becoming effective on July 1 of the following year. If any rate will decline by more than ten percent, the rate change will be phased-in over two years in order to allow time for providers to adjust and to avoid any disruption to existing employment placements. Specifically, if a rate will decline by more than ten percent, the total dollar reduction will be calculated, with one-half of this reduction being applied to the rate on July 1 per the schedule described. The second half of the reduction would be applied to the rate on the following July 1. Assumptions related to cost factors, such as staff wages, the cost of health insurance, the IRS' standard mileage rate, etc., may be reviewed more frequently.

Discovery and Job Development are reimbursed on an outcome basis with rates varying by level of need.

The following criteria must be met in order for the Discovery Service's one time outcome payment to occur:
• A Discovery Profile must be completed in a template that has been approved by ODDS.
• The completed Profile must include all information requested in the Department-approved Profile that pertains to the individual.
• The Case manager must review and approve the Profile to ensure it is complete, accurate, and includes all information the provider agreed to obtain under the terms of the ISP and service agreement. The case manager will also verify whether any requested work experiences were completed.

A referral to Vocational Rehabilitation services is an expected outcome of this service, but it is not required for payment. If the individual and his or her ISP team determine that a referral to Vocational Rehabilitation services is not appropriate, that decision is included in the Career Development Plan, part of the person-centered service plan. As when a referral is made, the Discovery Profile must still be completed and approved by the case manager in order for payment of the Discovery service to occur.

An individual can access this service more than once if there has been a significant change that has made a completed Discovery Profile substantially irrelevant. This is determined by the case manager, along with the individual and his or her person centered planning team. These circumstances might include, but are not limited to, a significant change in the individual's support needs, an interest in making a significant career change, or a significant move that includes a change in providers.

Job Development outcome payments are made in two increments. Each of the two outcome payments is for a separate and distinct outcome. The first payment is approved by the case manager upon job placement and the second is approved after the individual has retained the job for 90 calendar days.

For the job placement outcome payment to occur, the job developer must support the individual in obtaining individual integrated employment that pays minimum wage or better. The job placement must also meet any wage, hour or other job criteria identified as part of Career Development Planning or Individual Support Planning, and written into the person centered service plan and service contract. The case manager will approve the initial placement outcome payment upon verification that the job meets the criteria established.

For the second outcome payment to occur, the individual must retain the developed job for 90 calendar days. The case manager must verify that the job has been retained for 90 calendar days, and will then approve the second outcome payment. The outcome payments are the only payments made to the Job Developer and the Job Developer doesn't receive any payment unless the outcomes are achieved.

Job Development is only funded through ODDS when Vocational Rehabilitation is not able to provide the service. For that reason, ODDS has made an effort to better align our Job Development rates with the VR Job Placement rates.

The rate models for Job Development are based on the assumed number of hours needed to complete successfully place and maintain an individual in individual integrated employment. Information gathered through the provider survey indicated that this time varies based on individuals' level of need. Accordingly, there are different payment categories tied to each individual's assessed needs with higher rates paid for individuals with greater needs. Additionally, the information gathered from the provider survey indicated that the initial job placement requires more time than retention so more hours are built into the placement rates.

Appendix A: Waiver Administration and Operation

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.

(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:

Oregon Department of Human Services

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

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:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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:

Oregon Health Authority (OHA), the single state Medicaid Agency, and the Oregon Department of Human Services (ODHS), the Operating Agency, have an Interagency Agreement (IAA) that contains the following oversight functions to ensure that ODHS performs its assigned waiver operations and administrative functions in accordance with waiver requirements:
- Specifies that OHA maintains the authority on Medicaid costs.
- Specifies that OHA maintains authority for waiver applications, amendments and reporting requirements related to Medicaid waivers operated by ODHS.
- Requires that OHA maintain oversight of ODHS for the effective and efficient operation of Medicaid waiver programs and for the purpose of compliance with all required reporting and auditing of Medicaid waiver programs.
- Requires OHA and ODHS to have designated staff to coordinate through the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) for development of policy and oversight of waiver functions and quality assurance measures and outcomes.
- Grants to ODHS the responsibility for the operation of, and allowable Medicaid administrative activities for home and community-based waivers serving persons who are aged or physically disabled, or have developmental disabilities.
- Specifies that OHA has final approval of administrative rules and policies promulgated by ODHS that govern the waivers and is responsible for authorizing the submission of waiver applications and amendments to CMS in order to secure and maintain existing and proposed waivers. ODHS will provide policy, information, recommendations and participation to OHA through the MOCSC.
In addition to leadership-level meetings to address guiding policy, OHA ensures that ODHS performs assigned operational and administrative functions through the following:
- Regularly scheduled meetings of the MOCSC with staff from both OHA and ODHS to discuss:
o Information and correspondence received from CMS
o Proposed policy changes
o Waiver amendments and changes
o Data collection and quality assurance activities
o Waiver eligibility and enrollment
o Fiscal projections
o All other waiver related topics
- All policy changes related to the waivers are approved by OHA. The MOCSC will be the avenue through which policy changes are reviewed. Recommendation for approval will be provided to OHA for final approval.
- Waiver renewals, requests for amendments and 372 reports will be approved by OHA prior to submission to CMS.
- Correspondence with CMS is copied to OHA.
The Oregon Health Authority has oversight responsibility for all Medicaid programs, including the following functions related to HCBS waivers:
- Annual review of waiver enrollment measured against enrollment projections.
- Annual review of waiver expenditures measured against expenditure projections.
- Utilization management- OHA will review expenditures to ensure compliance with relevant statutory and regulatory authority and administrative rules and policies.
- Qualified Provider Enrollment and Termination - OHA will review provider enrollment and termination procedures and policies to ensure that Medicaid providers meet documented provider qualifications.
- Execution of Medicaid Provider Agreements - OHA will provide oversight to assure that Medicaid agreements are executed appropriately. OHA will also directly execute Medicaid agreements with providers choosing to contract directly with OHA.
- Rules, Policies, and Procedures Governing the Waiver Program- OHA will assist in the development, implementation and oversight of rules, policies and procedures governing the waiver program.
- Quality Assurance and Quality Improvement Activities - OHA will conduct it's own and review ODHS waiver assurances and standards of quality and remediation activities.

The following language is excerpted from the current Article III of the Interagency Agreement between the Oregon Health Authority and the Oregon Department of Human Services titled “Roles and Responsibilities”. The agencies renew this agreement every two years:
3.0.1 A Medicaid/CHIP Policy Steering Committee (Steering Committee) for OHA and ODHS will meet at least twice per year to review Medicaid/CHIP-related policy. The Steering Committee will be comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure

coordination of responsibilities, including establishment of a strategic plan for the two agencies.
3.0.2 A Medicaid/CHIP Operations Coordination Steering Committee (MOCSC)for OHA and ODHS will meet at least quarterly to coordinate all mutual policy issues related to the operation and administration of the Medicaid/CHIP program including state plan amendments, waiver requests, rules, procedures, and interpretive guidance. The MOCSC will be comprised of executive level staff and subject matter experts.
3.1.1 OHA, as the single state Medicaid/CHIP agency, has an administrative oversight function to ensure that all funds expended under such authority are spent in accordance with federal and state law, federal and state regulations, the State Plan, State Plan Amendments, and Waivers. In accordance with those functions:
A. Any Medicaid/CHIP program, project or expenditure which in whole or in part utilizes financial resources that are within OHA's legislative functions and duties, must have approval from OHA.
B. No ODHS Medicaid/CHIP project within OHA's functions and oversight responsibilities will be submitted to CMS for approval without prior approval by OHA. Projects will be developed according to the process description in Paragraph 3.0 of this Article.
3.1.2 OHA will exercise oversight of Medicaid/CHIP programs by participating in related committees and approving ODHS reports and documents as necessary. OHA will review ODHS quality control processes for Medicaid/CHIP programs managed by the ODHS to assure proper oversight of central office and field operations. This will include an initial review of program oversight activities during the first two years of this agreement and a follow up review during subsequent three-year periods thereafter.

3.2 RULE DEVELOPMENT AND IMPLEMENTATION
OHA as the single state Medicaid/CHIP agency is responsible for approving rules, regulations and policies that govern how the state plan and waivers are operated. Both agencies will work collaboratively in accordance with this Agreement, ensuring that OHA retains the authority to discharge its responsibilities for the administration of the Medicaid/CHIP program pursuant to 42 C.F.R. Sec. 431.10 (e).
Each year, OHA will review and approve annual CMS 372 reports for each waiver, reports of quality assurance performance outcomes across the spectrum of Medicaid state plan and waiver services offered, and reports of Medicaid policy or rule changes planned in the near term and long term.

Each year, OHA will review and approve annual CMS 372 reports for each waiver, reports of quality assurance performance outcomes across the spectrum of Medicaid state plan and waiver services offered, and reports of Medicaid policy or rule changes planned in the near term and long term.

Appendix A: Waiver Administration and Operation

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.:*

ODHS is a contracted entity, per the OHA/ODHS Interagency Agreement, that performs operational and administrative functions on behalf of the Medicaid Agency. Within the OHA/ODHS Interagency Agreement, Schedule C, OHA has designated ODHS as an Organized Health Care Delivery System, as defined in 42 CFR 447.10(b). As such, ODHS may contract with or enter into provider enrollment agreements, interagency agreements, grants or other similar arrangements with qualified individuals, entities or units of government to furnish Medicaid/CHIP administrative or programmatic services for which
ODHS has responsibility.

The agencies renew this agreement every two years.

○ **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

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

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:

Oregon Health Authority as Medicaid Agency and Oregon Department of Human Services as the OHCDS.

Appendix A: Waiver Administration and Operation

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:

OHA will exercise oversight of Medicaid/CHIP programs by participating in related committees and approving ODHS reports and documents as necessary. Each year, OHA will review and approve annual CMS 372 waiver reports for each waiver, reports of quality assurance performance outcomes across the spectrum of Medicaid state plan and waiver services offered, and reports of Medicaid policy changes planned in the near term and long term. OHA will review ODHS quality control processes for Medicaid/CHIP programs managed by ODHS to assure proper oversight of central office and field operations. OHA reviews program oversight on a continual basis and as described in the performance measures in the QIS. OHA will designate internal staff to review the processes employed, and outcomes reported, by ODHS in order to ensure prompt and accurate level of care determination, participant access to qualified providers, participant-centered service planning/delivery, enforcement of safeguards that ensure participant health and safety, and maintenance of financial accountability for all home and community-based waiver service levels.
The Medicaid/Chip Operations Coordination Steering Committee (MOCSC) is an internal leadership and governance body of OHA and ODHS, chartered in accordance with the IAA. MOCSC is co-chaired by representatives of OHA and ODHS appointed by the Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee). The MOCSC provides high level oversight and decision-making on the operations of the Medicaid/CHIP programs and monitors the interagency agreements between ODHS and OHA about Medicaid/CHIP program operations and their administrative issues.
Roles of the MOCSC include, but are not limited to:
- Providing high level oversight and decision-making on the operations of the Medicaid/CHIP programs;
- Ensuring the objectives of the interagency agreements between ODHS and OHA about Medicaid/CHIP program operations and their administrative issues are being met;
- Ensuring that members fully discuss Medicaid/CHIP business and fiscal and operations issues that require decisions and resolution;
- Providing a high-level forum for the regular exchange of information on Medicaid/CHIP operations.
- Providing recommendations to the Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee)that link the business objectives of OHA and ODHS (and the joint administrative processes applicable to Medicaid/CHIP programs operational and business processes) and may significantly affect both agencies; and
- Providing timely access, as needed by committees or workgroups, to review and recommend necessary actions, including an expedited review and decision-making process to accommodate time lines.
- Referring concerns or disagreements related to decisions by the MOCSC to Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee)
as appropriate.

Annual HCBS Waiver Review- of services for a statistically valid number of individuals in waiver services conducted by ODHS staff. Data is submitted to ODHS for entry into a central database and reporting. OHA will review a random sample of files already reviewed by ODHS to assure oversight and quality.

Office of Training, Information and Safety (OTIS) annual reports- statewide data by county, type, outcome, victim, perpetrator, provider, etc.;

OTIS review of abuse investigations;

Incident management teams review of provider sanctions- during regularly scheduled meetings.

Contested Case Review- As requested.

DD Complaints and Grievances Database- As requested.

ODHS Audit Unit, Secretary of State- other internal or external periodic audit activities.

Improvement Projects- Consumer satisfaction survey of in-home service recipients conducted approximately every 2 years.

The above-referenced Office of Training, Information and Safety, DD Licensing Unit, and incident management teams are all part of Oregon Department of Human Services, Oregon's operating agency.

Appendix A: Waiver Administration and Operation

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	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☐
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☒	☐
Level of care evaluation	☒	☒	☐
Review of Participant service plans	☒	☒	☐
Prior authorization of waiver services	☒	☒	☐
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☒	☐
Execution of Medicaid provider agreements	☒	☒	☒
Establishment of a statewide rate methodology	☒	☒	☒
Rules, policies, procedures and information development governing the waiver program	☒	☒	☐
Quality assurance and quality improvement activities	☒	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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:
PM3: Percentage of oversight of waiver amendments, renewals, 372 and evidence reports. N:Number of waiver amendments, renewals, 372 and evidence reports approved by OHA prior to Submission. D: Number of waiver amendments, renewals, 372 and evidence reports provided by ODHS

Data Source (Select one):
Operating agency 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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** 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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM4: The number and percent of Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) meetings held between the operating agency (OA) and the SMA per year (MOCSC meeting agendas cover ODHS QA& QI activities) N = Number of waiver management committee meetings held between the OA and the SMA per year D = Number of waiver management committee meetings scheduled.

Data Source (Select one):
Operating agency 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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** 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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM2: The number and percent of waiver amendments reviewed with Oregon's Tribal partners prior to submission to CMS N = Number of waiver amendments reviewed with Oregon's Tribal partners prior to submission to CMS D = Number of waiver amendments submitted to CMS.

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** 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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
PM1: Percentage of aggregated performance measure reports, trends, and remediation efforts reviewed by OHA. N: Number of aggregated performance measure reports, trends, and remediation efforts reviewed by OHA. D: Number of aggregated performance measure reports, trends, and remediation efforts generated by ODHS.

Data Source (Select one):
Operating agency 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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** 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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

Data and reports gathered and created by ODHS staff during quality reviews are reviewed and analyzed on a continuous and ongoing basis by designated OHA staff, including the OHA liaison to ODHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Upon completion of OHA's analysis and review of ODHS quality assurance data and reports, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document ODHS and OHA remediation efforts. The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and ODHS. The MOCSC meets at least quarterly to coordinate and review all mutual policy issues related to the operation and administration of the Medicaid/CHIP program including state plan amendments, waiver requests, rules, procedures, and interpretive guidance. A Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) for OHA and ODHS meets at least twice per year to review Medicaid/CHIP-related policy. The Steering Committee is comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of policy-related issues and delineation of responsibilities, including establishment of a strategic plan for the two agencies. ODHS staff address individual problems with designated OHA staff on an ongoing basis and during regularly scheduled meetings. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving ODHS reports, documents, rules, policies and guidelines. OHA, on a continuous and ongoing basis, reviews and provides input to ODHS quality control processes for Medicaid/CHIP programs managed by the ODHS to assure proper oversight of central office and field operations. This includes ongoing review and approval of ODHS operational oversight and quality assurance activities. As designated OHA staff, the OHA liaison, and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) outlined above, thus informing executive management of OHA and ODHS.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Individual remediation activities will require follow-up by the OHA and/or ODHS Quality Management Staff to determine that the corrective action was successfully completed by the field office, licensing or abuse investigation unit. The results of any remediation will be submitted to an inter-departmental workgroup for discussion, data collection and reporting. When individual and/or system-wide remediation activities are warranted based on discovery and analysis, the following time frames will be used to ensure these items are remediated in a timely manner. Because ODHS is monitoring the performance of its contractors (CDDPs and service providers) and OHA is monitoring the performance of its operating agency (ODHS) and reviewing ODHS monitoring of its contractors, the timelines for corrective action and remediation taken by each agency differ.
Non-compliance will be determined by any performance measure that falls below 86% accuracy.
ODHS timelines for remediation:
Corrective Action Plans: Within 45 days of Department's identification of need for plan of correction, entities reviewed must submit a plan of correction.
Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 45 days of Department's approval of entity's plan of correction.
Completion of corrective actions: Within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff)
OHA timelines for remediation:
Corrective Action Plans: OHA will determine the corrective action needed within 30 days of any OHA controlled performance measure falling below 86% compliance. Corrective actions will include revisions to administrative processes and procedures. Corrective actions will be completed within 60 days of discovery of non-compliance.
Timelines for systemic remediation:
Required system-wide changes: If changes require revision of administrative rules, the required changes will be completed within the time frames required by the administrative rule process, including Rule Advisory Committees (including stakeholder input), Administrative rule hearings and statutory filing time frames.
If system-wide changes require waiver amendments, the process will be completed at the time of approval of the waiver amendment. This will include the 30 day public and 60 day tribal input period and 90 day approval process.
Follow-up to determine effectiveness of remediation activities will occur during the next discovery and review cycle using a comparison of compliance level pre- and post-remediation to determine the level of success with the remediation activity. After initial remediation is completed a follow-up will occur within 180 days to determine the effectiveness of the method. If additional remediation is required, it will be added to the corrective action plan.
The Quality Improvement System will ensure that all discovery and remediation activities have a process in place to ensure system improvement. The Oregon Health Authority and Oregon Department of Human Services will
collaborate through inter-departmental meetings to coordinate these activities. These meetings will occur at least quarterly to report on the corrective actions and follow-up required to ensure system improvement.
Remediation strategies include training, revision of administrative processes and procedures, administrative rule revisions and waiver amendments. These strategies will be used based on the results of the discovery and analysis of the related performance measure. If compliance with the performance measure falls below 86%, a request for a corrective action plan, including activities and time lines for completion and follow-up will be required. Follow-up will include a discovery process using a valid random sample. Follow up discovery will be conducted using the standardized survey instruments and methods utilized during the initial discovery phase.

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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Specify:	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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 one or more groups 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 or more waiver target groups, check each of the subgroups in the selected target group(s) 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
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☒	**Medically Fragile**	0	17	☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Children with significant medical needs who score 45 or more on the MFCU Clinical Criteria. Children served under this waiver reside and receive services in their own or family home.

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 #0375 adult's waiver, or the #0185 Aged and Physically Disabled Waiver), as well as other state plan programs. Based on this assessment, individuals who meet eligibility will be referred by the case manager to the programs most appropriate to meet their needs and will coordinate with the receiving agency to transition individuals into their new programs based on the prioritization process established in the Oregon Administrative Rules 411-415-0030(2) for the respective 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	123
Year 2	123
Year 3	123
Year 4	123
Year 5	123

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	92
Year 2	95
Year 3	98
Year 4	111
Year 5	111

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, including eligible members of federally recognized tribes, with significant medical needs who score 45 or greater on the MFCU Clinical Criteria. Children who do not meet the waiver enrollment criteria will be referred to other services or programs.

WAIT LIST. If the maximum number of children allowed on the Medically Fragile Waiver are enrolled and being served, the Department may place a child eligible for the Medically Fragile Waiver on a wait list.

(a) The date of the initial completed application for the MFW determines the order on the wait list. A child who previously received the MFW, exited the MFW, reapplies for the MFW, and currently meets all other criteria for eligibility is put on the wait list as of the date the original application for the MFW was complete.]

(b) The date the application for the MFW is complete is the date that the Department has the required demographic data for the child.

(c) Children on the wait list are served on a first come, first served basis as space on the Medically Fragile Waiver allows. All candidates are re-evaluated prior to enrollment to ensure they still meet all criteria for enrollment.

Children who lose MFW eligibility due to change of physical medical, 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 SSI related groups and the following:

42 CFR 435.116 for pregnant woman, 435.118 for children and 435.110 for parents and other caretaker relatives and 435.145 for Children with adoption assistance, foster care, or guardianship care under title IV-E.

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 spend down 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 7)

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. 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:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **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 uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (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 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. 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:

○ **Other**

Specify:

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

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **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 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- (●) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The special income level for institutionalized persons**
- ( ) **A percentage of the Federal poverty level**

  Specify percentage:
- ( ) **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 formula:
- ( ) **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

  Explanation of difference:

iii. 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 uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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 (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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. 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 the selections in B-5-d also apply to B-5-g.

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: 1

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 a government agency 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 employees of ODHS, Office of Developmental Disabilities Services (ODDS), trained in the MFCU Clinical Criteria instrument. All employees must meet the qualifications as established in the ODHS/ODDS position specifications that require:

Knowledge of the public service system for developmental disability services in
Oregon and at least: A bachelor's degree in behavioral science, social science, or a closely related field; or A bachelor’s degree in any field and one year of human services related experience, such as work providing assistance to individuals and groups with issues such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing; or (C) An associate’s degree in a behavioral science, social science, or a closely related field and two years of human services related experience, such as work providing assistance to individuals and groups with issues such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing; or (D) Three years of human services related experience, such as work providing assistance to individuals and groups with issues such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing.

Employees receive additional training specific to the MFCU Clinical Criteria instrument. This includes reviewing the training guide and reviewing all process maps, intake processes specific to the Medically Fragile waiver. They also shadow other trained employees, and then are mentored as they complete the initial few MFCU Clinical Criteria’s they are assigned. In addition, all completed MFCU Clinical Criteria’s are reviewed by the program manager and are reviewed and approved by the OHA/ODHS Medical Director or designee to assure consistency in application of the scoring.

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 the Hospital Level of Care Medically Fragile Waiver are assessed using the MFCU Clinical Criteria, the level of care evaluation for this waiver population. Individuals must receive a score of 45 on the MFCU Clinical Criteria to qualify for this waiver. This applies to individuals being discharged from hospitals and to those who are being considered for admission from the community.

The MFCU Clinical Criteria instrument scores various care elements that the assessor expects to last six months or more. In addition to the "Overall" category that measures nursing and other intervention needs, the instrument measures the frequency and intensity of the care needed in the following: Skin/Physical Management; Metabolic: GI/Feeding; Neurological; Urinary/Kidney; Respiratory; and Vascular.

Individuals are admitted to hospitals based upon a physician's signature that hospital level of care is required. The Medically Fragile waiver level of care requires a physician's signature for determination of the need for hospital level of care. This process goes beyond what is required for hospitalization and is reliable, fully comparable, valid, and results in the same outcome.

The child must meet the following:
- Initially score 45 or greater as determined by the MFCU Clinical Criteria checklist instrument;
- Maintain a score on the MFCU Clinical Criteria checklist of 45 as re-evaluated every six months;
- Reside in the family home; and
- Be capable of being safely served in the family home within the limitations of applicable administrative rules.

Children who no longer meet the MFC Clinical Criteria will be provided an appropriate timely decision notice and will be assisted with transition into other services for which they may be eligible. Decision notices must be mailed at least 10 days prior to the action being taken, per Oregon Administrative Rule 461-175-0050. The notice will include the individual’s right to a Medicaid fair hearing and information regarding continuation of benefits during the hearing process. The case manager will assist families in determining eligibility for the Children's Waiver if the child meets ICF/ID level of care criteria. Other options may include State plan services or other community options. Continuation of services after the notice and hearing period is not subject to Federal Financial Participation.

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:

An initial level of care assessment occurs utilizing the MFCU Clinical Criteria instrument, conducting the review in the family home or medical facility on a face-to-face basis. The LOC assessment includes interviews with the child, family members, medical professionals, and others as appropriate, as well as reviewing the child's medical records. The MFCU Clinical Criteria score is communicated to the family and/or referring party. An initial score of 45 or greater will qualify the child for the waiver.

Every 6 months the LOC is reassessed by meeting with the child and family and completing the MFCU Clinical Criteria. Eligibility is maintained if the instrument score is 45 or greater. Children who fall below 45 will be transitioned off the waiver as described in Appendix B-6-d.

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 CME maintains a tickler system to remind the case manager 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:

The CME 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
PM5: Number and percent of new waiver applicants who had an approved initial LOC prior to waiver enrollment. N: Number of new waiver applicants who had an approved initial LOC prior to waiver enrollment. D: Total number of new waiver applicants reviewed.

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

Performance Measure:
PM6: Number and percent of waiver participants who were offered the choice of institutional services. N: Number of waiver participants who were offered the choice of institutional services. D: Total number of waiver participants reviewed.

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
Per CMS this performance measure should be removed as the sub-assurance is being eliminated.

Data Source (Select one):
Operating agency 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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☒ **Other** Specify: OHA will review a 10% sample of individual files reviewed by DHS during DHS' review.
	☒ **Other** Specify: biennially	

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify:

		A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: biennially	

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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

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 the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
PM7: Number and percent of LOCs that were completed based on the instruments in the approved waiver. N: Number of LOCs that were completed based on the instruments in the approved waiver. D: Total number of LOCs reviewed.

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

Performance Measure:
PM8: umber and percent of LOCs that were completed based on the processes in the approved waiver. N: Number of LOCs that were completed based on the processes in the approved waiver. D: Total number of LOCs reviewed.

Data Source (Select one):
Record reviews, on-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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

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.

The frequency of data collection, aggregation and analysis is biennial with site and file reviews conducted on an ongoing basis with reviews at each site every two years. The sample universe will be comprised of waiver year 1 and 2 for the #40193, #40194 and #0565 waivers combined, to determine the statistically valid representative random sample size. The file review sample size used for all measures in Appendix D and two of the appendix G performance measures is based on a statistically valid representative random sample utilizing a 95% confidence level, 5% margin of error and 50% response distribution, as determined by the Raosoft sample size calculator found at http://www.raosoft.com/samplesize.html for the two-year cycle. This representative sample is proportioned across case management entities based on the percentage of the population served relative to the waiver population size. Half of the sample will be pulled for participants who were enrolled in waiver year one and the other half pulled for participants enrolled in waiver year two. Within the sample drawn each year of the biennial cycle, Oregon will over sample to account for multiple variable review, as well as to account for 'non-response' factors such as participants who are no longer enrolled in the waiver due to relocation out of state or death and participants whose length of enrollment within the review period is insufficient to produce results for the variables measured (e.g., service plan updated annually cannot be assessed for someone who is newly enrolled for less than 12 months).

All other performance measures utilize a 100% review process of the total population for the review period for the unit of analysis of the measure (e.g., waiver participants, providers, claims).

Oregon's sampling methodology is informed by the Sampling Guide included in Attachment D of the 1915c HCBS Waiver Technical Guide Resource Attachments. In particular, this sampling methodology comports with guidance regarding proportionate sampling described on page 24 and oversampling to account for the number of variables to be examined and non-response rate, both described on page 21.

The 0565, 40193 and 40194 waivers meet the following five CMS conditions:
1. Design of the waivers is the same or very similar;
2. This sameness or similarity is determined by comparing waivers on the approved waiver application appendices:
a. Participant Services,
b. Participant Safeguards, and
c. Quality Management;
3. The quality management approach is the same or very similar across waivers, including:
a. Methodology for discovering information (e.g., data systems, sample selection),
b. Manner in which individual issues are remedied,
c. Process for identifying and analyzing patterns/trends, and
d. Majority of the performance indicators are the same;
4. The provider network is the same or very similar; and
5. Provider oversight is the same or very similar."
Data and reports gathered and created by ODHS staff during quality reviews are reviewed and analyzed on a continuous and ongoing basis by designated OHA staff, including the OHA liaison to ODHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Upon completion of OHA' analysis and review of ODHS quality assurance data and reports, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document ODHS and OHA remediation efforts.
The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and ODHS. The MOCSC meets at least quarterly to coordinate and review all mutual policy issues related to the operation and administration of the Medicaid/CHIP program including state plan amendments, waiver requests, rules, procedures, and interpretive guidance. A Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) for OHA and ODHS meets at least twice per year to review Medicaid/CHIP-related policy. The Steering Committee is comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of policy-related issues and delineation of responsibilities, including establishment of a strategic plan for the two agencies.
ODHS staff address individual problems with designated OHA staff on an ongoing basis and during regularly

scheduled meetings. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving ODHS reports, documents, rules, policies and guidelines. OHA, on a continuous and ongoing basis, reviews and provides input to ODHS quality control processes for Medicaid/CHIP programs managed by the ODHS to assure proper oversight of central office and field operations. This includes ongoing review and approval of ODHS operational oversight and quality assurance activities.
As designated OHA staff, the OHA liaison, and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Joint Policy and Operations Steering Committee outlined above, thus informing executive management of OHA and ODHS.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Individual remediation activities will require follow-up by the ODHS Quality Management
Staff to determine that the corrective action was successfully completed by the field office, licensing or abuse investigation unit. The results of any remediation will be submitted to an inter-departmental workgroup for discussion, data collection and reporting. When individual and/or system-wide remediation activities are warranted based on discovery and analysis, the following time frames will be used to ensure these items are remediated in a timely manner. Because ODHS is monitoring the performance of its contractors (CMEs, and service providers)
Non-compliance will be determined by any performance measure that falls below 86% accuracy.
ODHS timelines for remediation:
Corrective Action Plans: Within 45 days of Department’s identification of need for plan of correction, entities reviewed must submit a plan of correction.
Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 45 days of Department’s approval of entity’s plan of correction.
Completion of corrective actions: Within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff).
Timelines for systemic remediation:
Required system-wide changes: If changes require revision of administrative rules, the required changes will be completed within the time frames required by the administrative rule process, including Rule Advisory Committees (including stakeholder input), Administrative rule hearings and statutory filing time frames. If system-wide changes require waiver amendments, the process will be completed at the time of approval of the waiver amendment. This will include the 30 day public and 60 day tribal input period and 90 day approval process.
Follow-up to determine effectiveness of remediation activities will occur during the next discovery and review cycle using a comparison of compliance level pre- and post-remediation to determine the level of success with the remediation activity. After initial remediation is completed a follow-up will occur within 180 days to determine the effectiveness of the method. If additional remediation is required, it will be added to the corrective action plan.
The Quality Improvement System will ensure that all discovery and remediation activities have a process in place to ensure system improvement. The Oregon Health Authority and Oregon Department of Human Services will
collaborate through inter-departmental meetings to coordinate these activities. These meetings will occur at least quarterly to report on the corrective actions and follow-up required to ensure system improvement.
Remediation strategies include training, revision of administrative processes and procedures, administrative rule revisions and waiver amendments. These strategies will be used based on the results of the discovery and analysis of the related performance measure. If compliance with the performance measure falls below 86%, a request for a corrective action plan, including activities and time lines for completion and follow-up will be required. Follow-up will include a discovery process using a valid random sample. Follow up discovery will be conducted using the standardized survey instruments and methods utilized during the initial discovery phase.

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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: ODHS-Site/file reviews conducted ongoing with on-site reviews every two years OHA-reviews ODHS through regularly scheduled MOCSC meetings to identify trends that may require statewide QIS changes

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).

Oregon assures that individuals who are eligible for services under the waiver will be informed, during the eligibility process and initial completion of the level of care evaluation, of feasible alternatives for long-term services and supports and given a choice as to which type of services they are eligible to receive. When an individual is determined to require the level of care provided in a hospital, the individual or his or her legal or designated representative will be:
1) Informed of any feasible alternatives available under the waiver and Medicaid State Plan: and
2) Given the choice of either institutional or home and community-based services.
Case managers document the offer of choice on the choice form. The offer of choice is given before an individual is enrolled onto a waiver. The choice form is used to document that the offer of choice was presented to the individual or legal or designated representative, and how they indicated their choice of service. The individual's or legal or designated representative's signature is obtained when possible. If it is not possible to obtain their signature on the form, confirmation of the choice can be documented in the following manner: witnessed mark of the individual or legal or designated representative, letter from the legal or designated representative indicating choice, or witnessed and documented phone conversation with the individual or legal or designated representative regarding choice.

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.

The CMEs keeps the level of care 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):

CMEs address the language needs of the community being served through translated brochures, flyers and other relevant information regarding services. CMEs, when possible, employ bi-lingual case managers that reflect the primary local languages of the individuals and families within the county. CMEs collaborate with school districts and other local public entities to share interpretive services.
The Oregon Department of Human Services, Office of Equity and Multicultural Services provides guidance and technical assistance to ODHS in
fulfilling its responsibilities to provide meaningful access to limited English Proficient Persons (LEP). Language for LEP individuals can be a barrier to accessing important benefits or services, understanding and exercising important rights, complying with applicable responsibilities, or understanding other information provided by Federally funded programs and activities. In certain circumstances, failure to ensure that LEP persons can effectively participate in or benefit from Federally assisted programs, may violate Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d and Title VI regulations against national origin discrimination. ODHS receives funds from several Federal Agencies for an array of public health programs and services that fall under these requirements.
ODHS follows the Department of Administrative Services standards. ODHS is committed to improving the accessibility of these programs, services and activities to eligible LEP persons. When a Limited English Proficient (LEP) person attempts to access waiver services, ODHS notifies the person that language services are available. ODHS staff inform the LEP person that he or she has the option of having an interpreter without charge, or of using his or her own interpreter. Considerations are given to the circumstances of the LEP and whether there may be concerns over competency, confidentiality, privacy, or conflict of interest. ODHS staff are not allowed to use family members or friends as interpreters.
Many vital forms and notices are available for applicants and recipients in languages that are used by a significant number of individuals in the state. Most frequently, documents are translated into Russian, Vietnamese, and Spanish and are available on the Department's website or in hard copy at the local office.
Language assistance is available for verbal communications through a contractor.

Checklist to Facilitate the Development of Linguistic Competence within Primary Health Care Organizations (pdf):
Designed to assist primary health care organizations in developing policies, structures, practices and procedures that support linguistic competence.
Executive Order 13166[www.usdoj.gov]:
Improving Access to Services for Persons with Limited English Proficiency
Commonly Asked Questions And Answers Regarding Executive Order 13166
Multi-language Translations of Forms:
The documents on this website are intended to assist agencies that receive federal financial assistance in their planning efforts to ensure that their program services address meaningful access for all of the people they serve, including those who are limited English proficient. The responsibility to ensure access and understanding lies with ODHS not the individual.

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	**Employment Path Services**		
Statutory Service	**Supported Employment - Individual Employment Support**		
Statutory Service	**Waiver Case Management**		
Other Service	**Discovery/Career Exploration Services**		
Other Service	**Environmental Safety Modifications**		
Other Service	**Family Training**		
Other Service	**Individual Directed Goods and Services**		
Other Service	**Specialized Medical Supplies**		
Other Service	**Supported Employment - Small Group Employment Support**		
Other Service	**Vehicle Modifications**		

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:

Prevocational Services

Alternate Service Title (if any):

Employment Path Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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):*

Employment Path Services provide learning and work experiences, including volunteer opportunities, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employ ability in paid employment in integrated community settings. Employment path may also include benefits supports, training, and planning.
Services are expected to occur over a defined period of time, as outlined in each individual's ISP, and services and supports should be designed to support successful employment outcomes consistent with the individual's personal and career goals as identified in his or her ISP.
The optimal and expected outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated employment for which an individual is compensated at or above the state's minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
Services are intended to develop and teach general skills to improve an individual's ability to communicate effectively with supervisors, co-workers and customers; understanding of generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; understanding of general workplace safety.
Employment Path Services may be provided in integrated community settings and fixed-site facilities and are distinguishable from non-covered vocational services by the following criteria:
• The services are provided to individuals who are expected to be able to join the general work force with the assistance of supported employment services;
• The service is primarily directed at teaching non-job task specific skills that will lead to greater opportunities for competitive and integrated employment and career advancement at or above the state's minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities;
• The ISP does not define the goal or purpose of the service as maintaining the individual in Employment Path Services or sheltered work.
Employment Path Services should be reviewed and considered as a component of an individual's ISP no less than every 12 months and more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's personal and career goals. The presumption in considering these services is that all individuals eligible for services under this waiver are capable of working in an integrated employment setting and earning at least minimum wage. Consistent with the person-centered approach to these services, individuals should be encouraged, on an ongoing basis, to explore their interests, strengths, and abilities relating to integrated employment. As a component part of this service, employment service providers should be helping individuals identify and pursue career advancement opportunities that will move them toward individual integrated employment at competitive wage (with individual supported employment services as necessary
Discovery/Career Exploration services are detailed more fully and are billed separately under the Service Title: Discovery/Career Exploration Services contained in this waiver.
An individual's ISP may include more than one non-residential habilitation service; however, they may not be billed for during the same period of time (e.g., the same hour).
Participation in Employment Path Services is not a required pre-requisite for individual or small group supported employment services provided under the waiver.
Transportation provided during the course of this service is included as a component part of Employment Path Services and is included in the rate paid to providers for these services. Transportation between the individual's place of residence and an Employment Path service site is not a component part of the service and is not included in the rate paid to providers of these services.
Personal care/assistance may be a component of Employment Path services, but may not comprise the entirety of the service.

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

An individual may receive any combination of Small Group Employment Services, and Employment Path Services, the total of which (including any Supported Employment - Individual Employment services received) shall be in compliance with Oregon Labor Laws. The waiver will not cover services which are otherwise available to the individual under section 110 of the
Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid state plan services. Documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

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	Employment Path Services Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Path Services

Provider Category:

Agency

Provider Type:

Employment Path Services Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

OAR 411-340-0010 through 411-340-0180 or certificate issued by the Department to a service provider that certifies the service provider is eligible under the rules in OAR chapter 411, division 323.

Other Standard *(specify):*

Endorsement issued by the Department is also required for a certified service provider under OAR chapter 411, division 323 that has met the qualification criteria outlined in OAR 411-345-0010 - 411-345-0300.
Conditions that the Department may impose on an endorsement include but are not limited to: 1. Requiring additional staff or staff qualifications;
2. Requiring additional training;
For each specific geographic service area where services shall be delivered, a Medicaid Performing Provider Number assigned by the Department as described in OAR chapter 411, division 370.
Staff Qualifications:
1. Be at least 18 years of age;
2. Have approval to work based on current Department policy and procedures for background checks in OAR 407-007-0200 to 407-007-0370 and OAR 411-323-0050(6) of this rule;
3. Be literate and capable of understanding written and oral orders
4. Be able to communicate with individuals, physicians, case managers and appropriate others;
5. Be able to respond to emergency situations at all times;
6. Be certified in CPR and First Aid by a recognized training agency within 90 days of employment;
7. Receive six hours of pre-service training prior to supervising individuals including:
A. mandatory abuse reporting training,
B. training to work with individuals with developmental disabilities, and
C. training on the support needs of the individual to whom they will provide support;
8. Receive 12 hours of job-related in-service training annually;
9. Have clear job responsibilities as described in a current signed and dated job description; and
10. If transporting individuals, must meet applicable Oregon Driver and Motor Vehicle Services Division requirements, have a valid Oregon driver's license and proof of insurance.
11. Staff supporting an individual with a history of behavior requiring protective physical intervention must be trained by an instructor certified in OIS curriculum
12. Any other specialized training as specified by contract requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODHS

Frequency of Verification:

Initially and then every 2 years per OAR 411-323-0030.

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:

Supported Employment

Alternate Service Title (if any):

Supported Employment - Individual Employment Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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):*

Supported Employment--Individual Employment Support services are for individuals who, because of their disabilities, need on-going support to obtain and maintain a job in an integrated competitive, customized, or self-employment (including home-based) setting in the general workforce.
The optimal and expected outcome of this service is sustained paid employment in a competitive, customized, or self-employment setting, for which an individual is compensated at or above the state's minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. This service should be designed to support successful employment outcomes consistent with the individual's personal and career goals.
Supported employment- Individual Employment Support services are individualized and may include:
• Job coaching - initial, and ongoing for:
o Individuals working in an individualized job in an integrated setting and earning at least minimum wage;
o Identification and delivery of services and supports that assist the individual in maintaining self-employment through the operation of a business. Medicaid funds may not be used to defray the expenses associated with operating a business.
• Job Development
o Support to obtain a job in an integrated employment setting in the general workforce for which an individual is compensated at or above the minimum wage, but ideally not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
o Support to the individual in an individualized job in an integrated setting who is not earning at least minimum wage and who needs a different job to earn at least minimum wage.
o Support to the individual in identifying potential self-employment business opportunities and assistance in the development of a self-employment business plan, including potential sources of business financing and other assistance in developing and launching a business. Medicaid funds may not be used to defray the expenses associated with starting up a business.
The rate methodology for job development is an outcome payment for job placement and outcome payment for 90 day retention so it's not considered a direct and/or non-direct billable unit of service.
Leading up to job placement, the Job Developer's duties may include, but are not limited to, those outlined below in the "Between job placement and 90 day retention" section, as well as the following:
1. Supporting an individual to obtain an individual job in a competitive integrated employment setting in the general workforce, including customized employment or self-employment.
2. Working with the individual to develop a plan to obtain employment. Documenting or updating the individual's goals for employment, including the number of hours the individual wants to work, the wages and compensation the individual would like to receive in exchange for the work, as well as other career goals relating to the type of job the individual is interested in obtaining. The plan should also document the specific job development strategies to be used.
3. Meeting and networking with prospective businesses/employers to develop positive relationships and other staffing solutions. Support the individual in networking with businesses and prospective employers.
4. Meeting and partnering with Worksource Oregon, a statewide group of public and private partners dedicated to stimulating job growth by connecting businesses and workers with the resources they need to succeed. Worksource Oregon is one of many resources that a Job Developer can access in order to help link employers with employees. Meeting and partnering with Worksource could result in a possible job connection for the waiver participant and the individual may or may not go with the provider to meet/partner with Worksource.
5. Conducting labor market analyses to identify job opportunities that match an individual's career goals in terms of wages, hours, locating, interests and skills.
6. Supporting the individual and negotiate with prospective employers to carve or customize a job.
7. Evaluating potential employers, employer sites, and jobs, to identify potential obstacles, and negotiate for final job descriptions, including customized jobs, and, support the individual during the hiring and interview process.
Between job placement and 90 day retention, the Job Developer's duties may include, but are not limited to the following:
1. Establishing links with employers, in partnership with business services, to negotiate jobs with and for specific participants to obtain an individual job in a competitive integrated employment setting in the general workforce, including customized employment or self-employment.
2. Acting as the employer's primary contact during the supported individual's first 90 days on the job.
3. Following up with the employer and providing support to the individual during the negotiation of any additional reasonable accommodations needed or identified after job placement.
4. Providing support for any additional job carving needed after job placement.

5. Finalizing job designs and job and task analyses, including special considerations for support. This includes the identification of core job functions and identification of the related and subtle skills necessary for a worker to be successful in the job.
6. Evaluating the type and amount of job-task and social-task supports necessary for employment success.
7. Initiating relationships and facilitating natural supports with families, co-workers, supervisors, and other employer contacts. 2.
8. Maintaining continued contact with the employer, supported individual, and job coach, until the job is stable and the individual has maintained employment for at least 90 days. The retention outcome payment helps ensure and set the expectation that the job developer continues to play a role during the supported individual's initial days on the job, and ensure a smooth transition to the job coach.

Between job placement and 90 day retention, the Job Coach focuses on the direct support needs of the individual and has duties that may include, but are not limited to the following:
1. Providing training, systematic instruction, planning, and other workplace support services that enable the individual to be successful and integrated into the job setting. This might include, but is not limited to, training and systematic instruction regarding job related time management (punctuality, task speed), hygiene, organization (detail orientation, sorting/categorizing), self-advocacy, and disclosure.
2. Supporting the maintenance of relationships and natural supports with families, co-workers, supervisors, and other employer contacts that the Job Developer established.
3. Providing instruction and support to co-workers as needed (ie: augmented communication).
4. Developing and implementing techniques and strategies to fade supports as much as possible.
5. Supporting individuals using this service to assume full responsibilities for their jobs.

All supported employment service options should be reviewed and considered as a component of an individual's ISP no less than every 12 months and more frequently as necessary or as requested by the individual. The presumption in considering these services is that all individuals eligible for services under this waiver are capable of working in an integrated employment setting and earning at least minimum wage. Consistent with the person-centered approach to these services, individuals should be encouraged, on an ongoing basis, to explore their interests, strengths, and abilities relating to integrated employment. If an individual is employed and is already receiving supported employment services, Discovery/Career Exploration services may be used to find other competitive employment if the person wishes to seek additional hours of employment, to seek employment that is more consistent with the person's skills and interests or to explore advancement opportunities in his or her chosen career. Discovery/Career Exploration Services are detailed more fully and are billed separately under the Service Title: Discovery/Career Exploration Services contained in this waiver.
An individual's ISP may include more than one non-residential habilitation service; however, they may not be billed for during the same period of time (e.g., the same hour).
Ticket Outcome and Milestone payments do not conflict with CMS regulatory requirements and do not constitute an over payment of Federal dollars for services provided since payments are made for an outcome, rather than for a Medicaid service rendered.
Personal care/assistance may be a component of Individual Employment Support services, but may not comprise the entirety of the service.

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

This service does not include support for volunteering.
This service does not include payment for the supervisory activities rendered as a normal part of the business setting.
Transportation between the individual's place of residence and the employment site is not a component part of supported employment individual employment support services, and the cost of this transportation is not included in the rate paid to providers of these services. Transportation services may be available through another 1915 authority, such as the 1915 (k).
An individual may receive any combination of Small Group Employment Services, and Employment Path Services, the total of which (including any Supported Employment - Individual Employment services received) shall be in compliance with Oregon Labor Laws .
The waiver will not cover services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid state plan services. Documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or 2. Payments that are passed through to users of supported employment services.

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 Employment Support Provider
Agency	Individual Employment Support Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment - Individual Employment Support

Provider Category:

Individual

Provider Type:

Individual Employment Support Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

(a) Maintain a drug-free work place;
(b) Be at least 18 years of age;
(c) Have approval to work based on a background check completed by the Department as described in OAR 407-007-0200 to 407-007-0370 and section (7) of this rule, and be free of convictions or founded allegations of abuse by the appropriate agency including, but not limited to, the Department, CDDP, CIIS, or Support Services Brokerage;
(d) Not have been convicted of any of the disqualifying crimes listed in OAR 407-007-0275, unless hired or contracted with prior to July 28, 2009 and remaining in the original position for which the independent worker was hired or contracted for;
(e) Be legally eligible to work in the United States;
(f) may not provide or deliver services to their spouse.
(g) Demonstrate by background, education, references, skills, and abilities that the personal support worker is capable of safely and adequately performing the tasks specified in an ISP, with such demonstration confirmed in writing by an individual or the representative of the individual, including:
(A) Ability and sufficient education to follow oral and written instructions and keep any required records;
(B) Responsibility, maturity, and reputable character exercising sound judgment;
(C) Ability to communicate with the individual; and
(D) Training of a nature and type sufficient to ensure that the independent worker has knowledge of emergency procedures specific to the individual;
(h) Maintain confidentiality and safeguard individual information. Unless given specific permission by an individual or the representative of an individual, the independent worker may not share any personal information about the individual, including medical, social service, financial, public assistance, legal, or interpersonal details;
(i) Not be on the list of excluded or debarred providers maintained by the Office of the Inspector General (http://exclusions.oig.hhs.gov/);
(j) Complete and submit a Provider Enrollment Agreement to the Department and possess a current provider number issued by the Department;
(k) Have a tax identification number or social security number that matches the legal name of the independent worker, as verified by the Internal Revenue Service or Social Security Administration; and
(l) If providing in-home services requiring professional licensure, possess a current and unencumbered license. The individual, representative of the individual, Department, CDDP, CIIS, or Support Service Brokerage must check the license status to verify the license is current and unencumbered.
(m) Any other competencies or training as required by the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:

CME/ODDS

Frequency of Verification:

Upon initial enrollment as a service provider and at request of participant or designated representative.
All employment service providers are subject to the same competency-based training, qualification, and credentialing requirements. This information is verified annually by the case manager who authorize the Employment Service during the person centered planning process. It is also verified through both ODDS and Employment First Quality Assurance reviews.
Additionally, ODDS currently conducts criminal background checks and verifies other qualifications for independent providers every two years when provider enrollment agreements are completed.
If an independent contractor or other Personal Support Worker (PSW), subject to the Collective Bargaining Agreement (CBA), is providing an employment service, the Oregon Home Care Commission (OHCC) will coordinate with ODDS to verify training requirements are met. This verification will occur no less than every two years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment - Individual Employment Support

Provider Category:

Agency

Provider Type:

Individual Employment Support Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

OAR 411-340-0010 through 411-340-0180 or certificate issued by the Department to a service provider that certifies the service provider is eligible under the rules in OAR chapter 411, division 323.

Other Standard *(specify):*

Endorsement issued by the Department is also required for a certified service provider under OAR chapter 411, division 323 that has met the qualification criteria outlined in OAR 411-345-0010 - 411-345-0300.
Conditions that the Department may impose on an endorsement include but are not limited to:
1. Requiring additional staff or staff qualifications;
2. Requiring additional training;
For each specific geographic service area where services shall be delivered, a Medicaid Performing Provider Number assigned by the Department as described in OAR chapter 411,division 370.
Staff Qualifications:
1. Be at least 18 years of age;
2. Have approval to work based on current Department policy and procedures for background checks in OAR 407-007-0200 to 407-007-
0370 and OAR 411-323-0050(6) of this rule;
3. Be literate and capable of understanding written and oral orders
4. Be able to communicate with individuals, physicians, case managers, and appropriate others;
5. Be able to respond to emergency situations at all times;
6. Be certified in CPR and First Aid by a recognized training agency within 90 days of employment;
7. Receive six hours of pre-service training prior to supervising individuals including:
A. mandatory abuse reporting training,
B. training to work with individuals with developmental disabilities, and
C. training on the support needs of the individual to whom they will provide support;
8. Receive 12 hours of job-related in-service training annually;
9. Have clear job responsibilities as described in a current signed and dated job description; and
10. If transporting individuals, must meet applicable Oregon Driver and Motor Vehicle Services Division requirements, have a valid Oregon driver's license and proof of insurance.
11. Staff supporting an individual with a history of behavior requiring protective physical intervention must be trained by an instructor certified in OIS curriculum.
12. Any other specialized training as specified by contract requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODHS

Frequency of Verification:

Initially and then every 2 years per OAR 411-323-0030.

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:

Case Management

Alternate Service Title (if any):

Waiver Case Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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):*

Waiver Case Management is services furnished to assist individuals in gaining access to needed medical, social, educational and other services. Waiver Case Management includes the following assistance:
~Assessment and periodic reassessment of individual needs:
These annual assessment (more frequent with significant change in condition) activities include:
• Taking client history;
• Coordinate with state trained assessor who may conduct the functional needs assessment/LOC;
• Evaluation of the extent and nature of recipient's needs (medical, social, educational, and other services) and completing related documentation;
• Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
~Development (and periodic revision) of a specific care plan that:
• is based on the information collected through the assessment;
• specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
• includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
• identifies a course of action to respond to the assessed needs of the eligible individual.
~Referral and related activities:
To help an eligible individual obtain needed services including activities that help link an individual with:
• Medical, social, educational providers; or
• Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan such as making referrals to providers for needed services, and scheduling appointments for the individual.
~Monitoring and follow-up activities:

Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. The activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals to assure following conditions are met:
• Services are being furnished in accordance with the individual's care plan;
• Services in the care plan are adequate; and
• If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.
• Additional monitoring as needed which may include the review of records and encounter data to ensure that needed services are provided in accordance with the individual's person-centered service plan.
• Information and assistance in support of participant direction as it pertains to budget authority.

• Waiver case management may include contact with non-eligible individuals, that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))
Providers maintain case records that document for all individuals receiving case management as follows:
(I) The name of the individual;
(ii) The dates of the case management services;
(iii)The name of the provider agency (if relevant) and the person providing the case management service;
(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers/state trained assessors;
(vii) A timeline for obtaining needed services;
(viii) A timeline for reevaluation of the plan.
Providers of Waiver Case Management services are limited to employees of a Community Developmental Disabilities Program (CDDP), or other public or private agency contracted by a local community mental health authority or the Office of Developmental Disability Services (ODDS) Division.
• Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
• Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying

medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
• FFP only is available for case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

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

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	Case Manager
Agency	State Trained Assessor

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Waiver Case Management

Provider Category:

Agency

Provider Type:

Case Manager

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Case managers are employees of ODHS, Office of Developmental Disabilities Services (ODDS) Division and Community Developmental Disabilities Programs (CDDPs).
- 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
- An associate's degree in a behavioral science, social science, or a closely related field AND two years human services related experience; 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).

Verification of Provider Qualifications

Entity Responsible for Verification:

ODHS or CDDPs

Frequency of Verification:

At time of initial employment and upon promotion of the case manager.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Waiver Case Management

Provider Category:

Agency

Provider Type:

State Trained Assessor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

State trained assessors are employees of a Community Developmental Disabilities Program (CDDP), or employees of ODHS, Office of Developmental Disability Services (ODDS), or other public or private agency, contracted by a local community mental health authority or ODDS. These entities are also referred to as a case management entity.
State Trained Assessors must have knowledge of the public service system for developmental disability services in Oregon and at least:
~ a bachelor's degree in behavioral science, social science, or a closely related field; or
~ a bachelor's degree in any field AND one year of human services related experience; or
~ an associate's degree in a behavioral science, social science, or a closely related field AND two years human services related experience; or
~ three years of human services related experience.
~ODDS provided functional needs assessment initial training and ongoing training as needed.

Verification of Provider Qualifications

Entity Responsible for Verification:

CME or CDDP

Frequency of Verification:

At time of initial employment and upon promotion of the case manager.

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:

Discovery/Career Exploration Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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):*

Discovery/Career Exploration is a person-centered, comprehensive employment planning and support service that provides assistance for individuals to obtain, maintain or advance in a competitive, customized or selfemployment
setting. Discovery/Career Exploration services may include:
• Discovery to identify an individual's interests, strengths, abilities, transferable skills and conditions for success both generally and relating to employment, with the goal of attaining and maintaining employment paid at minimum wage or higher in an integrated employment setting, including self-employment;
• Job and task analysis activities;
• Review for need of assistive technology to promote increased independence in the workplace and if needs are identified a referral to the appropriate entity;
• Job shadowing;
• Informational interviewing (The beneficiary must be present for informational interviews completed as a part of the Discovery service);
• Employment preparation (i.e. resume development, work procedures);
• Volunteerism to assist the person in identifying transferable skills and job or career interests.
The outcome of this service is: 1) the development of a Discovery Profile, which provides employment-related information essential to the development of, or revision of, an individual's employment-related planning document, and 2) a referral to vocational rehabilitation services is expected, but not required for an outcome payment to occur.
Any of the above service components may be provided to someone considering or seeking employment, as well as someone who is already employed but who wishes to advance in his/her career or change careers.
Discovery/Career Exploration services should be reviewed and considered as a component of an individual's ISP no less than every 12 months and more frequently as necessary or as requested by the individual. The presumption in considering these services is that all individuals eligible for services under this waiver are capable of working in an integrated employment setting and earning at least minimum wage. Consistent with the person-centered approach to these services, individuals should be encouraged, on an ongoing basis, to explore their interests, strengths, and abilities relating to integrated employment. Services and supports should be designed to support successful employment outcomes consistent with the individual's personal and career goals.
An individual can access this service more than once if there has been a significant change that has made a completed Discovery Profile substantially irrelevant. This is determined by the case manager , along with the individual and his or her person centered planning team. These circumstances might include, but are not limited to, a significant change in the individual's support needs, an interest in making a significant career change, or a

significant move that includes a change in providers.
The individual's employment team, including the ISP team and representatives from vocational rehabilitation services, must monitor the Discovery service to ensure the work is adequate and complete. If the service is incomplete, the individual and his or her ISP team can request additional Discovery related activities. In more serious cases where the service is inadequate, the individual and his or her ISP team can request a different Discovery provider. Discovery cannot be billed if the service or Discovery Profile are inadequate or incomplete as determined by the ISP team.
Personal care/assistance may be a component of Discovery/Career Exploration services, but may not comprise the entirety of the service.

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

Discovery/Career Exploration services must be completed within a three-month period with a three month extension for legitimate cause upon ODDS approval.
The waiver will not cover services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid state plan services. Documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

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	Discovery/Career Exploration Services Provider
Agency	Discovery/Career Exploration Services Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Discovery/Career Exploration Services

Provider Category:
Individual
Provider Type:

Discovery/Career Exploration Services Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

(a) Maintain a drug-free work place;
(b) Be at least 18 years of age;
(c) Have approval to work based on a background check completed by the Department as described in OAR 407-007-0200 to 407-007-0370 and section (7) of this rule, and be free of convictions or founded allegations of abuse by the appropriate agency including, but not limited to, the Department, CDDP, or CIIS;
(d) Not have been convicted of any of the disqualifying crimes listed in OAR 407-007-0275, unless hired or contracted with prior to July 28, 2009 and remaining in the original position for which the independent worker was hired or contracted for;
(e) Be legally eligible to work in the United States;
(f) may not provide or deliver services to their spouse.
(g) Demonstrate by background, education, references, skills, and abilities that the personal support worker is capable of safely and adequately performing the tasks specified in an ISP, with such demonstration confirmed in writing by an individual or the representative of the individual, including:
(A) Ability and sufficient education to follow oral and written instructions and keep any required records;
(B) Responsibility, maturity, and reputable character exercising sound judgment;
(C) Ability to communicate with the individual; and
(D) Training of a nature and type sufficient to ensure that the independent worker has knowledge of emergency procedures specific to the individual;
(h) Maintain confidentiality and safeguard individual information. Unless given specific permission by an individual or the representative of an individual, the independent worker may not share any personal information about the individual, including medical, social service, financial, public assistance, legal, or interpersonal details;
(i) Not be on the list of excluded or debarred providers maintained by the Office of the Inspector General (http://exclusions.oig.hhs.gov/);
(j) Complete and submit a Provider Enrollment Agreement to the Department and possess a current provider number issued by the Department;
(k) Have a tax identification number or social security number that matches the legal name of the independent worker, as verified by the Internal Revenue Service or Social Security Administration; and
(l) If providing in-home services requiring professional licensure, possess a current and unencumbered license. The individual, representative of the individual, Department, CDDP, CIIS, or Support Service Brokerage must check the license status to verify the license is current and unencumbered.
(m) Any other competencies or training as required by the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:

CME/ODDS

Frequency of Verification:

Upon initial enrollment as a service provider and at request of participant or designated representative.
All employment service providers are subject to the same competency-based training, qualification, and credentialing requirements. This information is verified annually by the case manager who authorizes the Employment Services during the person centered planning process. It is also verified through both ODDS and Employment First Quality Assurance reviews.
Additionally, ODDS currently conducts criminal background checks and verifies other qualifications for independent providers every two years when provider enrollment agreements are completed.
If an independent contractor or other Personal Support Worker (PSW), subject to the Collective Bargaining Agreement (CBA), is providing an employment service, the Oregon Home Care Commission (OHCC) will coordinate with ODDS to verify training requirements are met. This verification will occur no less than every two years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Discovery/Career Exploration Services

Provider Category:

Agency

Provider Type:

Discovery/Career Exploration Services Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

OAR 411-340-0010 through 411-340-0180 or
Certificate issued by the Department to a service provider that certifies the service provider is eligible under the rules in OAR chapter 411, division 323.

Other Standard *(specify):*

chapter 411, division 323 that has met the qualification criteria outlined in OAR 411-345-0010 - 411-345-0300.
Conditions that the Department may impose on an endorsement include but are not limited to: 1. Requiring additional staff or staff qualifications;
2. Requiring additional training;
For each specific geographic service area where services shall be delivered, a Medicaid Performing Provider Number assigned by the Department as described in OAR chapter 411, division 370.
Staff Qualifications:
1. Be at least 18 years of age;
2. Have approval to work based on current Department policy and procedures for background checks in OAR 407-007-0200 to 407-007-0370 and OAR 411-323-0050(6) of this rule;
3. Be literate and capable of understanding written and oral orders
4. Be able to communicate with individuals, physicians, case managers, and appropriate others;
5. Be able to respond to emergency situations at all times;
6. Be certified in CPR and First Aid by a recognized training agency within 90 days of employment;
7. Receive six hours of pre-service training prior to supervising individuals including:
A. mandatory abuse reporting training,
B. training to work with individuals with developmental disabilities, and
C. training on the support needs of the individual to whom they will provide support;
8. Receive 12 hours of job-related in-service training annually;
9. Have clear job responsibilities as described in a current signed and dated job description; and
10. If transporting individuals, must meet applicable Oregon Driver and Motor Vehicle Services Division requirements, have a valid Oregon driver's license and proof of insurance.
11. Staff supporting an individual with a history of behavior requiring protective physical intervention must be trained by an instructor certified in OIS curriculum
12. Any other specialized training as specified by contract requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODHS

Frequency of Verification:

Initially and then every 2 years per OAR 411-323-0030.

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 Safety Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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):*

Those physical adaptations to the exterior of a participant's private residence or the participant's family, required by the service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence around the home.

Such adaptations typically include the installation of fencing, or pathways. Materials must be of the most cost effective type and decorative additions will not be considered. Modifications will not include additions that are non-essential to meeting the purpose of a goal stated in the service plan.

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

Fencing will be limited to 200 linear feet without approval from ODHS to exceed the limit. Large gates such as automobile gates are excluded. Costs for paint and stain are excluded.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence to accommodate a wheelchair). Also excluded are adaptations or improvements available under the state plan.

The services under this waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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	Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Safety Modifications

Provider Category:

Individual

Provider Type:

Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Licensed, bonded and insured. General contractors must have current Construction Contractors Board (CCB) license.

Verification of Provider Qualifications

Entity Responsible for Verification:

Family and/or CME

Frequency of Verification:

Provider qualifications are verified prior to service delivery and authorization of payment each time the service is provided.

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

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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):*

Training for family members who provide unpaid support, training, companionship and/or supervision to participants who self-direct their services.
For purposes of receipt of this service, “family” is defined as a unit of two or more persons that include at least one person with developmental disabilities where the primary caregiver(s) is (are):
(a) Related to the individual with developmental disabilities by blood, marriage or legal adoption; or
(b) In a domestic relationship where partners share:
(A) A permanent residence;
(B) Joint responsibility for the household in general (e.g. child-rearing, maintenance of the residence, basic living expenses); and
(C) Joint responsibility for supporting a member of the household with disabilities related to one of the partners by blood, marriage, or legal adoption.
This service may not be provided in order to train paid caregivers.
Training to family members includes:
-instruction about treatment regimens and other services included in the service plan;
-instruction about the use of equipment specified in the service plan; and/or
-information and education about the individual's disability, health and medical conditions, and includes updates as necessary to increase the family’s capability to care for their family member and safely maintain the participant at home.
Family Training may include attendance at conferences or group training.
Family Training services for family members who provide unpaid supports to the participant must be included in the ISP.
Family training supports do not duplicate any other Medicaid State Plan or waiver service.
FFP is available for the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the service plan. FFP is not available for the costs of travel, meals and overnight lodging to attend a training event or conference.

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

Prior authorization is required by case manager for attendance by family members at organized conferences and workshops.

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	Health Educator: Organized Conferences and Workshops

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:

Health Educator: Organized Conferences and Workshops

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Payment for families to attend organized workshops and conferences is limited to topics that are related to the individual's disability, identified support needs, or specialized medical or behavior support needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

CME

Frequency of Verification:

Prior to authorization of service 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:

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

17 Other Services	17010 goods and services

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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):*

Individual Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: the item or services would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participant's safety in the home environment; AND the participant does not have the funds to puschase the item or service or the item or service is not available through another source. Individual Directed Goods and Services must be documented in the service plan.

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

Experimental or prohibited treatments are excluded.

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

- [x] **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	Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Directed Goods and Services

Provider Category:

Individual

Provider Type:

Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must be authorized vendors of any goods or services.

Verification of Provider Qualifications

Entity Responsible for Verification:

CME and participant / designated representative.

Frequency of Verification:

Provider qualifications are verified prior to service delivery and authorization of payment each time the service is provided.

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:

Specialized Medical Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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 supplies include necessary medical supplies, specified in the service plan, not available under the State plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. Supplies includes ancillary supplies necessary to the proper functioning of items necessary for life support or to address physical conditions. All items shall meet applicable standards of manufacture, design and installation.

Supplies may also include supplies that are necessary for the continued operation of augmentative communication devices or systems.

Services provided under this waiver service are not covered by the Medicaid State Plan or the 1115 demonstration waiver. Through its 1115 demonstration waiver, Oregon has a waiver of EPSDT that allows Oregon to limit services to children only for covered services that are above the line on the prioritized list. Denial of special medical supplies through Oregon Health Authority, Health Systems Division must occur prior to funding supplies through the waiver.

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

The waiver will not cover services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid state plan services.

The services under this waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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	Medical Suppy Vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Supplies

Provider Category:

Agency

Provider Type:

Medical Suppy Vendors

Provider Qualifications

License *(specify):*

Retail business license.

Certificate *(specify):*

Other Standard *(specify):*

Specialized medical supplies will be obtained from authorized vendors of medical supply equipment.

Verification of Provider Qualifications

Entity Responsible for Verification:

CME

Frequency of Verification:

Prior to authorization and payment of service.

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:

Supported Employment - Small Group Employment Support

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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):*

Supported Employment - Small Group Employment Support are services and training activities provided in regular business, industry and community settings for groups of two (2) to eight (8) individuals with disabilities. Examples include mobile crews and other business-based workgroups. Services and training activities must be provided in a manner that promotes integration into the workplace and interaction with people without disabilities in those workplaces.
The optimal and expected outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated employment for which an individual is compensated at or above the state's minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. These services and supports should be designed to support successful employment outcomes consistent with the individual's personal and career goals.
All supported employment service options should be reviewed and considered as a component of an individual's ISP no less than every 12 months and more frequently as necessary or as requested by the individual. The presumption in considering these services is that all individuals eligible for services under this waiver are capable of working in an integrated employment setting and earning at least minimum wage. Consistent with the person-centered approach to these services, individuals should be encouraged, on an ongoing basis, to explore their interests, strengths, and abilities relating to integrated employment. As a component part of this service, employment service providers should be helping individuals explore, identify and pursue career advancement opportunities that will move them toward individual integrated employment at competitive wage (with individual supported employment services as necessary). Discovery/Career Exploration services are detailed more fully and are billed separately under the Service Title: Discovery/Career Exploration Services contained in this waiver.
An individual's ISP may include more than one non-residential habilitation services; however, they may not be billed for during the same period of time (e.g., the same hour).
Transportation provided during the course of Supported Employment—Small Group Employment Support is provided as a component part of Supported Employment –Small Group services and the cost of this transportation is included in the rate paid to providers of these services. Transportation between the individual's place of residence and the employment site is not a component part of the service and is not included in the rate paid to providers of these services.
Personal care/assistance may be a component of Small Group Employment Support services, but may not comprise the entirety of the service.

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

Small group employment support does not include vocational or employment path services provided in facility based work settings.
This Service does not include support for volunteering.
This service does not include payment for supervisory activities rendered as a normal part of the business setting.
An individual may receive any combination of Small Group Employment Services, and Employment Path Services, the total of which (including any Supported Employment - Individual Employment services received) shall be in compliance with Oregon Labor Laws .
The waiver will not cover services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). This service will not overlap with, supplant,or duplicate other services provided through the waiver or Medicaid state plan services. Documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment services;
2. Payments that are passed through to users of supported employment services; or
3. Payments for training that is not directly related to an individual's supported employment program.

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	Small Group Employment Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment - Small Group Employment Support

Provider Category:
Agency
Provider Type:

Small Group Employment Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Certificate issued by the Department to a service provider that certifies the service provider is eligible under the rules in OAR chapter 411, division 323.

Other Standard *(specify):*

Endorsement issued by the Department to a certified service provider that has met the qualification criteria outlined in OAR 411-345-0010 -411-345-0300 and OAR chapter 411, division 323.
Conditions that the Department may impose on an endorsement include but are not limited to:
1. Requiring additional staff or staff qualifications;
2. Requiring additional training;
For each specific geographic service area where services shall be delivered, a Medicaid Performing Provider Number assigned by the Department as described in OAR chapter 411, division 370.
Staff Qualifications:
1. Be at least 18 years of age;
2. Have approval to work based on current Department policy and procedures for background checks in OAR 407-007-0200 to 407-007-0370 and OAR 411-323-0050(6) of this rule;
3. Be literate and capable of understanding written and oral orders
4. Be able to communicate with individuals, physicians, case managers, and appropriate others;
5. Be able to respond to emergency situations at all times;
6. Be certified in CPR and First Aid by a recognized training agency within 90 days of employment;
7. Receive six hours of pre-service training prior to supervising individuals including:
A. mandatory abuse reporting training,
B. training to work with individuals with developmental disabilities, and
C. training on the support needs of the individual to whom they will provide support;
8. Receive 12 hours of job-related in-service training annually;
9. Have clear job responsibilities as described in a current signed and dated job description; and
10. If transporting individuals, must meet applicable Oregon Driver and Motor Vehicle Services Division requirements, have a valid Oregon driver's license and proof of insurance.
11. Staff supporting an individual with a history of behavior requiring protective physical intervention must be trained by an instructor certified in OIS curriculum
12. Any other specialized training as specified by contract requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODHS

Frequency of Verification:

Initially and then every 2 years per OAR 411-323-0030.

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:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The following are specifically excluded:
1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;
2) Purchase or lease of a vehicle; and
3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

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

The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.
The waiver will not cover services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid state plan services.

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	Vehicle modification vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Individual

Provider Type:

Vehicle modification vendors

Provider Qualifications

License *(specify):*

General business license

Certificate *(specify):*

Other Standard *(specify):*

Bonded and insured

Verification of Provider Qualifications

Entity Responsible for Verification:

CME

Frequency of Verification:

Provider qualifications are verified prior to service delivery and authorization of payment each time the service is provided.

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.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *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:

Case management is provided by state employees of ODDS Children's Intensive In-home Services unit and Community Developmental Disabilities Programs (CDDPs).

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 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. Criminal history checks are conducted initially and every two years thereafter. All potential providers are screened against the ODHS Child Welfare abuse and neglect registry. If there is a child abuse or neglect finding, the case manager contacts the child welfare case worker 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 5 years, a national fingerprint check will be completed. Every criminal history is reviewed by the ODHS Criminal Records Unit and reviewed by the case manager for final determination. No provider receives a provider number for payment of services until a criminal record check and 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. The CME references the State of Oregon Child Abuse registry for anyone applying to be a provider for a child as part of the criminal history check. The Oregon Child Abuse database is maintained by the ODHS Child Welfare office.
Prospective employers can contact the Office of Adult Abuse Prevention and Investigations (OAAPI) within ODHS 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.
(b) The CME must conduct a review of the Oregon Child Abuse registry for any provider of services providing intensive in-home services to children. All provider applicants are screened through this abuse registry. It is sorted by perpetrator name. The abuse registry is the only abuse registry available to the CME.
The CME also conducts criminal history checks through ODHS Background Check Unit.
(c) The CME 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 case manager and family are informed and the hiring process may begin.

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

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.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

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.*

  Relatives may provide Supported Employment - Individual Employment Support and are required to meet the same qualifications set forth in Appendix C-1/C-3 and Oregon Administrative Rule. Relatives who are identified as providers in the service plan are verified as being in the best interest of the consumer by the individual, and as applicable the legal or designated representative, and case manager. Anyone identified as a provider, including relatives cannot be responsible for directing ISP development.

  All providers, including relatives, work under signed service agreements that specify the services to be provided. Time sheets and/or invoices that describe the service provided are verified by the individual, and as applicable the legal or designated representative or may be confirmed by the case manager. No providers, including relatives, may sign off on their own time sheets or invoices showing the hours worked.
  Relatives may provide the services identified in the approved waiver for which they meet provider qualifications, based on the individual's assessed needs and identified in the approved ISP. Services provided, regardless of the provider, must be in accordance with any limits identified in the waiver and set forth in OARs.

  Relatives may only be paid when a conflict of interest is not present and the relative meets the qualifications, and is chosen by the individual. Oregon issued the policy transmittal on March 3, 2015 regarding conflict of interest. Exceptions to this policy may only be granted by ODDS. Requests for exception must be submitted to the Funding Review Committee. Requests should include a demonstration of effort to resolve any conflicts of interest through a thorough exploration of service setting options, a thorough exploration of available providers, and an inability to locate a qualified and willing designated representative.

  As determined during the provider enrollment process, The case manager reviews applicants to assure they have completed the credentialing process, and that they do not meet any of the exclusion categories cited in rule. Payment may be made to any relative who does not meet the criteria in
  OAR 411-375-0020 (2) the following are excluded from being a paid provider:
  (a) An employee of the State of Oregon may not be authorized to deliver services as a personal support worker.
  (b) An independent provider may not be authorized to deliver services to an individual in any of the following circumstances:
  (A) The individual is less than 18 years of age and the independent provider is the parent of the individual.
  (B) The independent provider is the legal representative of the individual and has not appointed a designated representative to plan supports for the individual.
  (C) The independent provider is the designated representative of the individual.
  (D) The independent provider is the spouse of the individual.
  (E) The independent provider is the common law employer or the proxy of the common law employer

- ○ **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:

There is continuous, open enrollment of providers, including members of federally recognized tribes. A potential provider may apply for enrollment at any time.

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 ODHS 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 Oregon Department of Human Services make provider enrollment materials available to any individual agency or organization that wishes to become a provider. Families may, with the assistance of the case manager, advertise for providers through a variety of media, including the Internet.
ODHS and the CME 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by 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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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:
PM9: Number and percent of provider applicants who initially obtain the appropriate certification/licensure/endorsement prior to rendering waiver services.
N: Number of provider applicants who initially obtained the appropriate certification/licensure/endorsement prior to rendering waiver services. D: Total number of provider applicants who rendered waiver services.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐	
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially.

Performance Measure:
PM10: Number and percent of providers who continually meet the appropriate certification, licensure and/or endorsement N:Number of providers who continually meet the appropriate certification, licensure and/or endorsement D: Total number of providers who rendered waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
operating agency monitoring provider qualifications

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially.

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

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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:
PM11: Number and percent of enrolled non-licensed/non-certified providers who adhere to waiver requirements ongoing. Numerator: Number of enrolled nonlicensed/ non-certified providers who adhere to waiver requirements ongoing. Denominator: Total number of enrolled non-licensed/non-certified providers reviewed.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially.

Performance Measure:
PM12: Number and percent of newly enrolled non-licensed/non-certified providers who adhere to waiver requirements. Numerator: Number of newly enrolled non-licensed/non-certified providers who adhere to waiver requirements. Denominator: Total number of newly enrolled non-licensed/non-certified providers reviewed.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially.

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 the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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:
PM13: Number and percent of enrolled providers who meet training requirements ongoing. Numerator: Number of enrolled providers who meet training requirements ongoing. Denominator: Total number of providers reviewed.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐	
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially.

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.

The frequency of data collection, aggregation and analysis is biennial with site and file reviews conducted on an ongoing basis with reviews at each site every two years. The sample universe will be comprised of waiver year 1 and 2 for the #40193, #40194 and #0565 waivers combined, to determine the statistically valid representative random sample size. The file review sample size used for all measures in Appendix D and two of the appendix G performance measures is based on a statistically valid representative random sample utilizing a 95% confidence level, 5% margin of error and 50% response distribution, as determined by the Raosoft sample size calculator found at http://www.raosoft.com/samplesize.html for the two-year cycle. This representative sample is proportioned across case management entities based on the percentage of the population served relative to the waiver population size. Half of the sample will be pulled for participants who were enrolled in waiver year one and the other half pulled for participants enrolled in waiver year two. Within the sample drawn each year of the biennial cycle, Oregon will over sample to account for multiple variable review, as well as to account for 'non-response' factors such as participants who are no longer enrolled in the waiver due to relocation out of state or death and participants whose length of enrollment within the review period is insufficient to produce results for the variables measured (e.g., service plan updated annually cannot be assessed for someone who is newly enrolled for less than 12 months).

All other performance measures utilize a 100% review process of the total population for the review period for the unit of analysis of the measure (e.g., waiver participants, providers, claims).

Oregon's sampling methodology is informed by the Sampling Guide included in Attachment D of the 1915c HCBS Waiver Technical Guide Resource Attachments. In particular, this sampling methodology comports with guidance regarding proportionate sampling described on page 24 and oversampling to account for the number of variables to be examined and non-response rate, both described on page 21.

The 0565, 40193 and 40194 waivers meet the following five CMS conditions:
1. Design of the waivers is the same or very similar;
2. This sameness or similarity is determined by comparing waivers on the approved waiver application appendices:
a. Participant Services,
b. Participant Safeguards, and
c. Quality Management;
3. The quality management approach is the same or very similar across waivers, including:
a. Methodology for discovering information (e.g., data systems, sample selection),
b. Manner in which individual issues are remedied,
c. Process for identifying and analyzing patterns/trends, and
d. Majority of the performance indicators are the same;
4. The provider network is the same or very similar; and
5. Provider oversight is the same or very similar."
Data and reports gathered and created by ODHS staff during quality reviews are reviewed and analyzed on a continuous and ongoing basis by designated OHA staff, including the OHA liaison to ODHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Upon completion of OHA' analysis and review of ODHS quality assurance data and reports, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document ODHS and OHA remediation efforts.
The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and ODHS. The MOCSC meets at least quarterly to coordinate and review all mutual policy issues related to the operation and administration of the Medicaid/CHIP program including state plan amendments, waiver requests, rules, procedures, and interpretive guidance. A Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) for OHA and ODHS meets at least twice per year to review Medicaid/CHIP-related policy. The Steering Committee is comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of policy-related issues and delineation of responsibilities, including establishment of a strategic plan for the two agencies.

ODHS staff address individual problems with designated OHA staff on an ongoing basis and during regularly scheduled meetings. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving ODHS reports, documents, rules, policies and guidelines. OHA, on a continuous and ongoing basis, reviews and provides input to ODHS quality control processes for Medicaid/CHIP programs managed by the ODHS to assure proper oversight of central office and field operations. This includes ongoing review and approval of ODHS operational oversight and quality assurance activities.
As designated OHA staff, the OHA liaison, and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Joint Policy and Operations Steering Committee outlined above, thus informing executive management of OHA and ODHS.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Individual remediation activities will require follow-up by the ODHS Quality Management
Staff to determine that the corrective action was successfully completed by the field office, licensing or abuse investigation unit. The results of any remediation will be submitted to an inter-departmental workgroup for discussion, data collection and reporting. When individual and/or system-wide remediation activities are warranted based on discovery and analysis, the following time frames will be used to ensure these items are remediated in a timely manner. Because ODHS is monitoring the performance of its contractors (CMEs, and service providers)
Non-compliance will be determined by any performance measure that falls below 86% accuracy.
ODHS timelines for remediation:
Corrective Action Plans: Within 45 days of Department’s identification of need for plan of correction, entities reviewed must submit a plan of correction.
Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 45 days of Department’s approval of entity’s plan of correction.
Completion of corrective actions: Within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff).
Timelines for systemic remediation:
Required system-wide changes: If changes require revision of administrative rules, the required changes will be completed within the time frames required by the administrative rule process, including Rule Advisory Committees (including stakeholder input), Administrative rule hearings and statutory filing time frames. If system-wide changes require waiver amendments, the process will be completed at the time of approval of the waiver amendment. This will include the 30 day public and 60 day tribal input period and 90 day approval process.

Follow-up to determine effectiveness of remediation activities will occur during the next discovery and review cycle using a comparison of compliance level pre- and post-remediation to determine the level of success with the remediation activity. After initial remediation is completed a follow-up will occur within 180 days to determine the effectiveness of the method. If additional remediation is required, it will be added to the corrective action plan.
The Quality Improvement System will ensure that all discovery and remediation activities have a process in place to ensure system improvement. The Oregon Health Authority and Oregon Department of Human Services will
collaborate through inter-departmental meetings to coordinate these activities. These meetings will occur at least quarterly to report on the corrective actions and follow-up required to ensure system improvement.
Remediation strategies include training, revision of administrative processes and procedures, administrative rule revisions and waiver amendments. These strategies will be used based on the results of the discovery and analysis of the related performance measure. If compliance with the performance measure falls below 86%, a request for a corrective action plan, including activities and time lines for completion and follow-up will be required. Follow-up will include a discovery process using a valid random sample. Follow up discovery will be conducted using the standardized survey instruments and methods utilized during the initial discovery phase.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: ODHS-Site/file reviews conducted ongoing with on-site reviews every two years OHA-reviews ODHS through regularly scheduled MOCSC meetings to identify trends that may require statewide QIS changes

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

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

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 C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

1. All individuals served under this waiver reside in their own or family home. The regulations allow states to presume the enrollee's private home or the relative's home in which the enrollee resides meet the requirements of HCB settings. Individuals receive all of their waiver services in their own homes and at sites that are in the general community that are accessible to the general public.
2. The State has assessed these settings and found individuals receiving waiver services have the same accessibility as individuals who do not receive services, which meet the HCBS regulations requirements.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Service Plan (ISP)

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:
- ☐ **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) Oregon Administrative Rules (OAR Chapter 411, Division 415) and ISP manual, incorporated by reference in the Oregon Administrative Rules, establish standards for the development of service plans called Individual Support Plans (ISPs).
Through a process known as choice advising, all individual and family/legal or designated representative, receive information on service options, service provider options, and HCBS setting options from their case manager prior to an initial ISP, at the renewal of an ISP, and as needed. Additionally, a case management entity (CME)is required to provide information and technical assistance to an individual and family/legal or designated representative of the individual, in order to make informed decisions. This may include, but is not limited to, information about support needs, settings, programs, and types of providers. Also, the case manager must provide a description of the services available from the case management entity, including typical timelines for activities, required assessments, monitoring and other activities required for participation in a Medicaid program, and the planning process.
The standards for the development and implementation of an ISP require that it is developed using a person-centered planning process in order to assist with establishing outcomes, planning for supports, and reviewing and redesigning support strategies. The case manager must also facilitate active participation of the individual and family/legal or designated representative throughout the planning process.
(b) The ISP is developed by the individual and family/legal or designated representative and the case manager. Others may be included as a part of the ISP team at the invitation of the individual and family/legal or designated representative. Services included in an ISP may not begin until authorized by the signature of not only the case manager, but of the individual and/or family/legal or designated representative, thus assuring their involvement in and agreement to its content. In the case of an emergency, when a local, county or state emergency has been declared, the face to face requirement may be waived and signatures may be obtained by the use of e-signatures or email that meets privacy and security requirements as a method for the participant or legal guardian signing the ISP to indicate approval of the plan. Once the emergency declaration has ended, regular monitoring requirements will resume as specified in the person’s ISP, to assure the person’s health and welfare. This proposed request is specific to the ISP meeting only and does not waive any monitoring requirements currently in place.
- The assessor performing the assessment is independent and qualified as defined in § 42 CFR 441.730 and meets the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology.
- The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff.
- The individual provides informed consent for this type of assessment.

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) All individuals receiving services are required to have an authorized Individual Support Plan (ISP), using the standardized form SDS 4118, prior to the start of 1915(c) waiver and 1915(k) services, and renewed every 12 months.
The ISP is a holistic service plan that includes all components, strategies and protocols necessary for the individual to be healthy and safe. It includes the services to be received, Medicaid and non Medicaid. It also includes the scope amount, duration, frequency, and provider type. The ISP is developed, reviewed and updated during a face-to-face ISP meeting with the individual and family/legal or designated representative. ISP meetings are held at least every 12 months, or more frequently as needed due to changes in support needs or as requested by the individual and family/legal or designated representative. In the case of an emergency, when a local, county or state emergency has been declared, the face to face requirement may be waived and signatures may be obtained by the use of e-signatures or email that meets privacy and security requirements as a method for the participant or legal guardian signing the ISP to indicate approval of the plan. Once the emergency declaration has ended, regular monitoring requirements will resume as specified in the person's ISP, to assure the person's health and welfare. This proposed request is specific to the ISP meeting only and does not waive any monitoring requirements currently in place.
- The assessor performing the assessment is independent and qualified as defined in § 42 CFR 441.730 and meets the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology.
- The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff.
- The individual provides informed consent for this type of assessment.

b) The ISP development incorporates the assessment process which includes the gathering of person centered information by the individual's case manager as well as a functional needs assessment, including risks, conducted by a state trained assessor or the person's case manager. Input into the person centered information comes from the person in services and their family/legal or designated representative and anyone else they invite to contribute. The individual's case manager captures the information on a standardized form recording the person's and their family's/ legal or designated representative's perspective about a wide range of areas in his or her life. The case manager notes what is important TO the individual through this process. The content of this document informs the development of the ISP and is used to ensure that individual preferences, goals and desired outcomes are addressed throughout. In the case of an emergency, when a local, county or state emergency has been declared, the face to face requirement may be waived and signatures may be obtained by the use of e-signatures or email that meets privacy and security requirements as a method for the participant or legal guardian signing the ISP to indicate approval of the plan. Once the emergency declaration has ended, regular monitoring requirements will resume as specified in the person's ISP, to assure the person's health and welfare. This proposed request is specific to the ISP meeting only and does not waive any monitoring requirements currently in place.
- The assessor performing the assessment is independent and qualified as defined in § 42 CFR 441.730 and meets the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology.
- The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff.
- The individual provides informed consent for this type of assessment.

Person Centered Information is completed as part of the individual's initial ISP. It is reviewed every 12 months and updated as needed. A functional needs assessment, also completed as part of the development of an ISP, is conducted by a state trained assessor or by a case manager. The assessment is based on observation of the individual, review of the record, and interviews with the individual and family/legal or designated representative and those chosen by the individual and family/legal or designated representative to provide information. The information gathered contributes to what
is important FOR the person and identifies support needs within the functional areas of:
- Communication
- ADL and IADL tasks
- Behavior
- Safety
- Medical

Included in the ISP is a Risk Management Plan with a description of what supports are available in the person's life to address each risk. This could include protocols designed to train staff and others on how to assist in managing the risk. Risks considered to be "high risks" are so identified, and prompt monthly monitoring.

During the development of an ISP, the individual's case manager and family/legal or designated representative help the individual to identify desired outcomes. Desired Outcomes are what drive a person's ISP.
These are personal goals; things that the person is interested in trying, learning, doing, or achieving in the next year or as a longer termed outcome. Desired Outcomes must relate to what is important TO the person—desired outcomes are not simply support needs, although they may contain components of supports a person needs in specific areas or with specific tasks.

c) A case manager assists an individual and family/legal or designated representative to identify services and supports that will help to achieve the desired
outcomes. As described in Appendix D.1.c., the individual and family/legal or designated representative, through the process of choice advising, are informed of the available service options. The ISP
authorizes services that are requested to achieve the desired, identified outcomes. These services address support needs identified by the person centered planning process. During a meeting which includes, at a minimum, the case manager and the individual and family/legal or designated representative, desired outcomes are established and the supports necessary to achieve them are identified. Other attendees at the ISP meeting participate at the invitation of the individual and family/legal or designated representative. When a requested service or provider is reduced, denied or terminated the individual is given an opportunity for a Fair Hearing.

d) Under certain circumstances when support needs may not be well known or desired outcomes are not able to be articulated, such as when an individual enters into a significantly different type of program or setting, a 60 day transition period may exist.
At the start of this period, an ISP authorizes the services and supports believed by the case manager to be necessary to preserve the health and
safety of the individual. During the 60 days, the case manager and others who may be involved with the individual refine the assessment information and learn the individual's preferences, goals, etc. Before the end of the 60 day period the case manager is required to review and update the ISP as needed to reflect any new information.

e) The ISP process is designed to coordinate waiver and other services. Through the tools and the established process for developing the ISP, functional support needs, health risks, safety issues, and preferences are assessed and discussed. The ISP and other tools may identify the need to develop support documents such as: protocols to address specific health; financial plan to support a person's self-determination and financial health; safety plan to assure that processes are in place to mitigate any harm. These support documents can result in the acquisition of other Medicaid or non Medicaid services for the individual.

f)Attendant Care available through the 1915(k) state plan amendment, when delivered by an individual (non-agency) provider, is considered participant
directed. When these services are selected, the case manager reviews the employer responsibilities associated with participant direction with the individual and family/legal or designated representative, including:
• Locating, screening, and hiring a qualified provider.
• Ensuring services are delivered in accordance with the ISP.
• Supervising and training the provider.
• Scheduling work, leave, and coverage.
• Tracking the hours worked and verifying the authorized hours completed by the provider.
• Recognizing, discussing, and attempting to correct, with the provider, any performance deficiencies and provide appropriate and progressive disciplinary action as needed.
• Notifying the case management entity of any suspected fraud or abuse by the provider.
• Discharging an unsatisfactory provider.
The individual and family/legal or designated representative may choose to carry out all or some of these responsibilities. They may designate a proxy to fulfill specific
responsibilities while retaining overall direction of the services, or they may delegate all of the responsibilities to another person, who will act as the employer of the individual provider on behalf of the individual.

g) Case managers are responsible for monitoring the individual's services to assure that the ISP is implemented and that waiver and other services are coordinated, provided and meet the individual's service and support needs as identified in the functional needs assessment and ISP. The ISP document includes a field for identifying who is responsible, timelines, where progress is noted and any additional implementation strategies for assisting the individual to achieve each desired outcome.

The ISP is considered to be a “living” document, and should be changed and updated as an individual’s support needs or preferences change. Any member of the individual’s ISP team, including the individual and family/legal or designated representative, can request a
meeting to review changes in preference or need. This may prompt the review of the functional needs assessment or other supporting documents and tools, including updating them with new or additional information as indicated. If a change to the individual’s ISP is made, it must be documented by the case manager on the appropriate ISP change form, with a progress note in the case file, documenting the specific change(s) being made, the reason for the change (s), where the change will be documented, and ISP team review and approval of the change(s).
The individual and family/legal or designated representative, the case manager and others who may have participated in the development of the ISP sign the ISP document. Signatures indicate “These people agree to this plan and associated documents as reflecting the person’s strengths and preferences, support needs as identified by an assessment, and the services and supports that will assist the person to achieve their identified desired outcomes." The ISP is distributed to the individual and other people involved in the implementation of the plan. In the case of an emergency, when a local, county or state emergency has been declared, the face to face requirement may be waived and signatures may be obtained by the use of e-signatures or email that meets privacy and security requirements as a method for the participant or legal guardian signing the ISP to indicate approval of the plan. Once the emergency declaration has ended, regular monitoring requirements will resume as specified in the person’s ISP, to assure the person’s health and welfare. This proposed request is specific to the ISP meeting only and does not waive any monitoring requirements currently in place.

- The assessor performing the assessment is independent and qualified as defined in § 42 CFR 441.730 and meets the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology.
- The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff.
- The individual provides informed consent for this type of assessment.

Appendix D: Participant-Centered Planning and Service Delivery

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.

The ISP is required to be developed based on an assessment process which includes the gathering of person centered information by the individual's case manager as well as the functional needs assessment, including risks, conducted by a state trained assessor or case manager.
The functional needs assessment is a standardized assessment constructed to identify risks related to aspiration, dehydration, choking, constipation, seizures, and other health risks. The functional needs assessment prompts evaluation of the risk for abuse, for mental health concerns, and challenging behaviors. When an individual is identified as having three or more high risks, the ISP is required to include that the case manager will provide at least monthly monitoring to assure the individual's ongoing health and safety. A serious risk is one that, without support, would likely result in hospitalization, institutionalization, legal action, or place the person or others in imminent harm.
A Behavior Support Plan (BSP) is a support document used when interventions are needed for identified behavioral risks. A BSP outlines strategies to ensure the safety of the individual and others through positive supports when the individual engages in challenging behaviors, and must be written in accordance with OARs specific to behavior supports found in OAR chapter 411, division 304.
The ISP form has a section known as the Risk Management Plan. For each known risk, the strategy to mitigate it is identified in the Risk Management Plan section of the ISP. Each strategy must be developed with the individual and family/legal or designated representative's preferences for supports and cannot be included in the ISP if not agreed to by the individual and family/legal or designated representative. An individual and family/legal or designated representative may choose to leave a risk unaddressed after being informed of potential consequences and available supports. This information is captured in the ISP.
The risk management plan also includes prompts to address emergency preparedness (in the event of natural disasters, power outages, etc.), abuse prevention, and emergency contacts. The ISP has a section for back up plans in the event a primary support is unavailable. These are specific to the individual and based on the unique circumstances and preference of the individual and family/legal or designated representative.
Case managers assist families in developing emergency procedures and backup plans. Case managers can assist the family to identify family members and potential providers who can act as backup and assist families that have difficulties in finding and keeping providers through support with advertising and contacting community resources. Since children served on the waiver live in the family home, the family is ultimately responsible for backup services when providers are unavailable. While case managers can assist in locating services and in developing a backup plan, they cannot impose a specific provider or backup plan on the family. Examples of options discussed with families include using a provider agency rather than an individual provider. If the family uses a provider agency, the agency is responsible to seek backup providers.

Appendix D: Participant-Centered Planning and Service Delivery

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.

The waiver service of case management operates under a concurrent 1915(b) waiver of free choice of provider. However, OAR Chapter 411 Division 415 does assure that the individual receiving services, and family/legal or designated representative, may request a new case manager within the same case management entity.
Providers of other waiver services are made known to the individual and family/legal or designated representative through the choice advising process.
The Case Manager provides information to the individual and family/legal or designated representative about service options, provider options, and HCB setting options per OAR Chapter 411 Division 415. Additionally, a case management entity is required to provide information and technical assistance to an individual and family/legal or designated representative of the individual, in order to make informed decisions. This may include, but is not limited to, information about support needs, settings, programs, and types of providers.

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):

ODHS is responsible for certain Medicaid/CHIP services as an Organized Health Care Delivery System, providing program administration and as a direct service provider, as outlined in the agreement for services, including but not limited to:
1. Waiver Case Management (WCM) for all applicable programs administered by ODHS;
2. Home and Community-Based Services for programs operated by ODHS; and
3. Other services provided in accordance with the Medicaid/CHIP state plan such as personal care services, contracted nursing services, and rehabilitative services, to the extent such services are administered by ODHS.

ODHS staff compile, review and analyze performance data through a variety of file reviews and data reports.

1. ODHS generates A random statewide sample of the combined populations of waivers 0565, 40193 & 40194 with a confidence interval = 95%/5%/50% to determine sample size. The reviews occur over the course of a two-year cycle, beginning in July and ending in June two years later.

2. ODHS conducts comprehensive reviews of each CME's case management services, including service plans, once every two years.

3. Each CME knows the month and year which their review will occur. However, the individuals pulled from the sample are not shared with the CME until approximately 1 month prior to the review. ODDS' QA unit will conduct an onsite visit at each CME and each file audited includes a thorough review of the individual's:
a. Service Plan to ensure:
i. The plan is based on an assessment of individual need
ii. Health and safety risks are addressed
iii. The plan reflects individual choice, including but not limited to choice of services and providers
iv. Is implemented appropriately (finalized and signed; completed within 12 months of the previous plan)
b. Monitoring of services, including assessment that current plan continues to meet individual's needs, including health and safety risks; that the person is satisfied with their services; and whether or not changes to the current plan needs to be made.
c. Health and Welfare, including notification of abuse reporting process, and follow up on any serious events
d. Complaints
e. Qualified Case Management Encounters
f. Home and Community Based Service rule compliance.
4. Remediation: A draft of the final report is submitted to the CME within 30 days of the conclusion of the onsite field review. The CME has up to 45 days to contest findings and to submit a corrective action plan. At the conclusion of the 45 days, a final report is issued and the CME has up to 60 days to correct identified deficiencies. The CMEs are responsible to provide evidence of correction to ODDS. Once it is determined the CME has addressed all required actions identified in the corrective action plan, the CME is informed there will be no additional follow up and the formal review process is closed.
5. Follow up—If ODDS has concerns about any aspect of the CMEs ability to provide compliant services, a follow up review may be scheduled. These reviews may target specific aspects of the CME's case management activities or a full review of all CME services may be conducted.
6. Collaboration with Medicaid agency (OHA): All final reports are sent to OHA for review. While they do not authorize the final report, they have the opportunity to follow up on the results of each review conducted.

A statewide report documenting key performance measures and remediation outcomes is provided to the OHA/ODHS Liaison and the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The OHA/ODHS Liaison and the MOCSC reviews annual reports on key performance measures to ensure follow-up and compliance. Additionally, OHA staff reviews a percentage of the files reviewed by ODHS to demonstrate oversight and assure quality and compliance of the Medicaid programs for which ODHS is responsible to administer.
The CME management looks at a representative sample of ISPs as part of QA and case review activities in order to ensure that
ISPs meet program standards.
Appendix D performance measures include both a ODHS and OHA review of the ISP to ensure the ISPs are developed and implemented in accordance with the waiver.

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 case manager is responsible for monitoring the implementation of the service plan and provides oversight of health and welfare. CME supervisory staff periodically review plans and make visits to family homes to assure the service plan has been implemented as written.
Children enrolled in ODDS Medically Fragile Children's Waiver #40193 receive services in their own or family home and have full access to the community. These individuals do not reside in provider-owned, controlled or operated residential settings. A primary focus of case managers for children served is to address how the child can maximize opportunities for full access in their community.
(b) As required by OAR Chapter 411 Division 415, every individual who has an ISP must have a case management contact no less than once every three months. Individuals with three or more high risks as identified in the functional needs assessment, or if determined to be necessary by the case manager, must have monthly case management contact. At least one case management contact per year must be face to face. If an individual or legal representative requests, other case management contact may be made by telephone or by other interactive methods, depending upon the individual's preference. The purpose of the case management contact is:

- To assure known health and safety risks are adequately addressed;
- To assure that the support needs of an individual have not significantly changed; and
- To assure that an individual and designated representative is satisfied with the current supports.

In addition, as required by OAR a case manager must conduct service monitoring activities at a frequency established in the ISP, based on the individual's circumstances, but at a minimum of once per year, that includes an assessment of the following:

- Are services being provided as described in the ISP and do the services result in the achievement of the identified action plans?
- Are the personal, civil, and legal rights of the individual protected in accordance with Oregon Administrative Rules?
- Are the personal desires of the individual, and as applicable the legal or designated representative or family of the individual, addressed?
- Do the services authorized in the ISP continue to meet the assessed needs of the individual and what is important to, and for, the individual?

An individual's ISP identifies back up plans. An ineffective back up plan would be identified in response to the case manager's assessment of the question "Do services authorized in the ISP continue to meet the assessed needs of the individual and what is important to and for the individual?" insofar as services would not be meeting assessed needs.
Quarterly, at a minimum, case management contacts are used to assure health and safety through reciprocal contact with the participant or the participant's legal representative.

- Do identified desired outcomes and associated goals and action plans remain relevant and are the goals supported and being met?
- Are technological and adaptive equipment and environmental modifications being maintained and used as intended?
- Have changing needs or availability of other resources altered the need for continued use of Department funds to purchase supports?
- Are the services delivered in a setting that is in compliance with HCBS setting rules?

This assessment may be made based on direct observation of the individual, interviews with the individual and others who know the individual and the circumstances, including care givers. Progress notes submitted by care givers in support of reimbursement claims may serve as the basis for an indirect monitoring review, as can documentation reporting unusual incidents. A case manager and the CME are responsible for ensuring the appropriate follow-up to monitoring of services. If the case manager determines that developmental disabilities services are not being delivered as agreed in the ISP for an individual, or that the service needs of an individual have changed since the last review, the case manager must update the ISP of the individual and/or provide or refer technical assistance to an agency provider or to the person directing the implementation of the plan.

ODHS conducts comprehensive reviews of each CME's case management services, including service plans, once every two years and will conduct an onsite visit at each CME. Each file audited includes a thorough review of the individual's: a. Service Plan to ensure: i. The plan is based on an assessment of individual need ii. Health and safety risks are addressed iii. The plan reflects individual choice, including but not limited to choice of services and providers iv. Is implemented appropriately (finalized and signed; completed within 12 months of the previous plan) b. Monitoring of services, including assessment that current plan continues to meet individual's needs, including health and safety risks;

that the person is satisfied with their services; and whether or not changes to the current plan needs to be made. c. Health and Welfare, including notification of abuse reporting process, and follow up on any serious events d. Complaints e. Qualified Case Management Encounters f. Home and Community Based Service rule compliance.

(c) Monitoring will occur as frequently as identified in Waiver Case Management, defined in Appendix C-1/C-3, and includes monitoring the requirement for the individual to maintain an MFCU clinical criteria score of 45 every 6 months. Oregon requires annual face to face level of care assessment. Additionally, there is a minimum, quarterly reciprocal case management contact required with either the individual or the designated representative if the individual has 2 or fewer identified high risks as assessed using a risk assessment process which contributes to the ISP. Three or more identified high risks prompts monthly monitoring regarding issues of health and safety. When a change in need is identified by the individual, family, provider or during a monitoring visit, a new functional needs assessment is conducted which can result in a change to the ISP, including identification of new support needs and risk mitigation strategies. Additional monitoring is individualized, based on the needs of the individual and documented in progress notes and the ISP.

Case managers/CMEs are required to notify the department of problems identified during monitoring as outlined in ODDS Worker Guides and Policy Transmittals found on the ODDS website. Systemically, information about monitoring results is compiled through the ODHS quality assurance review process completed by the ODHS Quality Management staff to determine that the corrective action was successfully completed. Data and reports gathered and created by ODHS staff during quality reviews are reviewed and analyzed by designated OHA staff, including the OHA liaison to ODHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Upon completion of OHA' analysis and review of ODHS quality assurance data and reports, all relevant information from both agencies' reviews are compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document ODHS and OHA remediation efforts.

ODHS will conduct quarterly system's improvement meetings to review and analyze indicators of success related to the current ODDS strategic plan. Participant feedback on system-wide data and trends will be used to develop and prioritize strategies that lead to the implementation of system improvements. Meeting participants will include representatives from a broad stakeholder base, which includes people receiving services, family members, service providers, case management representatives, ODDS representatives and others determined appropriate or invited by the ODDS Director or designee.

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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
PM16: Number and percent of waiver participants whose current service plans address assessed risks and safety factors. N: Number of waiver participants whose current service plans address assessed risks and safety factors. D: Total number of waiver participants reviewed

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify:

		A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

Performance Measure:
PM14: Number and percent of waiver participants whose service plans include services and supports that address assessed needs. Numerator: Number of waiver participants whose service plans include services and supports that address assessed needs. Denominator: Total number of waiver participants reviewed.

Data Source (Select one):

Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

Performance Measure:
PM15: Number and percent of waiver participants whose service plans address personal goals and preferences. Numerator: Number of waiver participants whose service plans address current service plans addresses personal goals and preferences. Denominator: Total number of waiver participants reviewed.

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: Bienially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
Per CMS this performance measure should be removed as the sub assurance is being eliminated.

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☒ **Other** Specify: A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: biennially	

Data Source (Select one):
Operating agency 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☒ **Other** Specify: OHA will review a 10% sample of individual files reviewed by DHS during DHS' review.
	☒ **Other** Specify: biennially	

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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
PM17: Number and percent of waiver participants whose service plan was revised, as needed, to address changing needs. Numerator: Number of service plans revised, as needed, to address changing needs. Denominator: Total number of waiver participants reviewed in which the need for service plan revisions were indicated.

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify:

		A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

Performance Measure:
PM18: Number and percent of waiver participants whose service plan was updated/revised every 12 months. Numerator: Number of service plans that were updated/revised every 12 months. Denominator: Total number of waiver participants reviewed.

Data Source (Select one):

Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

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 the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
PM 22: Number and percent of waiver participants whose services were delivered in the duration specified in the service plan. N: Number of waiver participants whose services were delivered in the duration specified in the service plan D: Total number of waiver participants reviewed

Data Source (Select one):
Record reviews, on-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):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

Performance Measure:
PM19:Number and percent of waiver participants whose services were delivered in the type specified in the service plan. N: Number of waiver participants whose services were delivered in the type specified in the service plan D: Total number of waiver participants reviewed

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☒ **Other** Specify: A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

Performance Measure:
PM 23: Number and percent of waiver participants whose services were delivered in the frequency specified in the service plan. N: Number of waiver participants whose services were delivered in the frequency specified in the service plan D: Total number of waiver participants reviewed

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify:	

	Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

Performance Measure:
PM 20: Number and percent of waiver participants whose services were delivered in the scope specified in the service plan. N: Number of waiver participants whose services were delivered in the scope specified in the service plan D: Total number of waiver participants reviewed

Data Source (Select one):
Operating agency 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

Performance Measure:
PM 21: Number and percent of waiver participants whose services were delivered in the amount specified in the service plan. N: Number of waiver participants whose services were delivered in the amount specified in the service plan D: Total number of waiver participants reviewed

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify:

		A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
PM24: Number and percent of waiver participants who are offered the choice among waiver services. N: Number of waiver participants who are offered choice among waiver services. D: Total number of waiver participants reviewed

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.

	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

Performance Measure:
PM25: Number and percent of waiver participants who are offered choice among providers N: Number of waiver participants who are offered choice among providers D: Total number of waiver participants reviewed

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

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.

The frequency of data collection, aggregation and analysis is biennial with site and file reviews conducted on an ongoing basis with reviews at each site every two years. The sample universe will be comprised of waiver year 1 and 2 for the #40193, #40194 and #0565 waivers combined, to determine the statistically valid representative random sample size. The file review sample size used for all measures in Appendix D and two of the appendix G performance measures is based on a statistically valid representative random sample utilizing a 95% confidence level, 5% margin of error and 50% response distribution, as determined by the Raosoft sample size calculator found at http://www.raosoft.com/samplesize.html for the two-year cycle. This representative sample is proportioned across case management entities based on the percentage of the population served relative to the waiver population size. Half of the sample will be pulled for participants who were enrolled in waiver year one and the other half pulled for participants enrolled in waiver year two. Within the sample drawn each year of the biennial cycle, Oregon will over sample to account for multiple variable review, as well as to account for 'non-response' factors such as participants who are no longer enrolled in the waiver due to relocation out of state or death and participants whose length of enrollment within the review period is insufficient to produce results for the variables measured (e.g., service plan updated annually cannot be assessed for someone who is newly enrolled for less than 12 months).

All other performance measures utilize a 100% review process of the total population for the review period for the unit of analysis of the measure (e.g., waiver participants, providers, claims).

Oregon's sampling methodology is informed by the Sampling Guide included in Attachment D of the 1915c HCBS Waiver Technical Guide Resource Attachments. In particular, this sampling methodology comports with guidance regarding proportionate sampling described on page 24 and oversampling to account for the number of variables to be examined and non-response rate, both described on page 21.

The 0565, 40193 and 40194 waivers meet the following five CMS conditions:
1. Design of the waivers is the same or very similar;
2. This sameness or similarity is determined by comparing waivers on the approved waiver application appendices:
a. Participant Services,
b. Participant Safeguards, and
c. Quality Management;
3. The quality management approach is the same or very similar across waivers, including:
a. Methodology for discovering information (e.g., data systems, sample selection),
b. Manner in which individual issues are remedied,
c. Process for identifying and analyzing patterns/trends, and
d. Majority of the performance indicators are the same;
4. The provider network is the same or very similar; and
5. Provider oversight is the same or very similar."
Data and reports gathered and created by ODHS staff during quality reviews are reviewed and analyzed on a continuous and ongoing basis by designated OHA staff, including the OHA liaison to ODHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Upon completion of OHA' analysis and review of ODHS quality assurance data and reports, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document ODHS and OHA remediation efforts.
The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and ODHS. The MOCSC meets at least quarterly to coordinate and review all mutual policy issues related to the operation and administration of the Medicaid/CHIP program including state plan amendments, waiver requests, rules, procedures, and interpretive guidance. A Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) for OHA and ODHS meets at least twice per year to review Medicaid/CHIP-related policy. The Steering Committee is comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of policy-related issues and delineation of responsibilities, including

establishment of a strategic plan for the two agencies.
ODHS staff address individual problems with designated OHA staff on an ongoing basis and during regularly scheduled meetings. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving ODHS reports, documents, rules, policies and guidelines. OHA, on a continuous and ongoing basis, reviews and provides input to ODHS quality control processes for Medicaid/CHIP programs managed by the ODHS to assure proper oversight of central office and field operations. This includes ongoing review and approval of ODHS operational oversight and quality assurance activities.
As designated OHA staff, the OHA liaison, and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Joint Policy and Operations Steering Committee outlined above, thus informing executive management of OHA and ODHS.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Individual remediation activities will require follow-up by the ODHS Quality Management
Staff to determine that the corrective action was successfully completed by the field office, licensing or abuse investigation unit. The results of any remediation will be submitted to an inter-departmental workgroup for discussion, data collection and reporting. When individual and/or system-wide remediation activities are warranted based on discovery and analysis, the following time frames will be used to ensure these items are remediated in a timely manner. Because ODHS is monitoring the performance of its contractors (CMEs, and service providers)
Non-compliance will be determined by any performance measure that falls below 86% accuracy.
ODHS timelines for remediation:
Corrective Action Plans: Within 45 days of Department’s identification of need for plan of correction, entities reviewed must submit a plan of correction.
Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 45 days of Department’s approval of entity’s plan of correction.
Completion of corrective actions: Within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff).
Timelines for systemic remediation:
Required system-wide changes: If changes require revision of administrative rules, the required changes will be completed within the time frames required by the administrative rule process, including Rule Advisory Committees (including stakeholder input), Administrative rule hearings and statutory filing time frames. If system-wide changes require waiver amendments, the process will be completed at the time of approval of the waiver amendment. This will include the 30 day public and 60 day tribal input period and 90 day approval process.
Follow-up to determine effectiveness of remediation activities will occur during the next discovery and review cycle using a comparison of compliance level pre- and post-remediation to determine the level of success with the remediation activity. After initial remediation is completed a follow-up will occur within 180 days to determine the effectiveness of the method. If additional remediation is required, it will be added to the corrective action plan.
The Quality Improvement System will ensure that all discovery and remediation activities have a process in place to ensure system improvement. The Oregon Health Authority and Oregon Department of Human Services will
collaborate through inter-departmental meetings to coordinate these activities. These meetings will occur at least quarterly to report on the corrective actions and follow-up required to ensure system improvement.
Remediation strategies include training, revision of administrative processes and procedures, administrative rule revisions and waiver amendments. These strategies will be used based on the results of the discovery and analysis of the related performance measure. If compliance with the performance measure falls below 86%, a request for a corrective action plan, including activities and time lines for completion and follow-up will be required. Follow-up will include a discovery process using a valid random sample. Follow up discovery will be conducted using the standardized survey instruments and methods utilized during the initial discovery phase.

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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: ODHS-Site/file reviews conducted ongoing with on-site reviews every two years OHA-reviews ODHS through regularly scheduled MOCSC meetings to identify trends that may require statewide QIS changes

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

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.

(a) ODHS provides opportunities for the individual and family/legal or designated representative to exercise budget Authority over Individual Goods and Services. Because IDGS with budget authority only includes items purchased through qualified vendors, the standard Medicaid payment mechanism, eXPRS is used rather than an FMS. It is during the ISP planning process that the need for IDGS with budget authority is identified and authorized by the case manager. The case manager then tracks expenditures for IDGS via the eXPRS payment system. Expenditures and updates regarding the status of authorized IDGS are reviewed with the individual and family during regularly occurring case management contacts. The ISP is considered a “living” document and should be changed and updated to reflect an individual’s changes in support needs or preferences, including IDGS with budget authority.
Employer Authority is allowed in Supported Employment - Individual Employment Support (Job Coaching). A person-centered planning approach is required which assists the individual and family/legal or designated representative to establish outcomes, determine needs, plan for supports, and review and redesign support strategies. The planning process must address basic health and safety needs and supports, including informed decisions by the individual and family/legal or designated representative regarding any identified risks. A comprehensive needs assessment is completed for all individuals. (b) The case manager will discuss all waiver services options with every eligible individual and family/legal or designated representative who chooses home and community-based services. (c) 1) Information and assistance in support of participant direction: ~ Case managers assist individual and family/legal or designated representative in creating an individualized support plan based upon assessments of disability related needs during which time they provide information to the individual and family/legal or designated representative regarding participant direction of Services. ~ Case managers provide information to individual and family/legal or designated representative regarding other agencies or organizations within the county that maintain lists of potential providers. All providers must meet minimum qualifications as defined by Oregon Administrative Rules including a criminal history check conducted by ODHS. Participants select their own providers. ~ Supports to the employer include, but are not limited to: education about employer responsibilities; orientation to basic wage and hour issues; use of common employer-related tools such as job descriptions; and fiscal intermediary/employer agent services. ~ The case manager monitors the service plan, identifying risks and unmet needs and discussing options with the individual and family/legal or designated representative. At a minimum, reassessments of the functional abilities and unmet needs are completed every 12 months. Case managers are expected to identify and monitor more closely if the situation warrants, for example if the individual's health is particularly fragile, if there are provider issues, mental health concerns or protective service issues. 2) Financial management services: ODHS contracts with an outside Fiscal Intermediary (FI)/Employer Agent (EA) to perform the FI/EA duties. The CME is jointly responsible with the FI/EA for assuring financial management services are provided appropriately. The FI/EA issues payment to the qualified provider and handles employer-related financial requirements on behalf of the participant-employer. The participant-employer signs off on time sheets and invoices verifying the number of hours their employee worked, up to the maximum hours authorized by the Individual Support Plan. Case managers, by direct or telephone contact with the participant, may also verify services provided. Case managers may assist the participant with creating job descriptions and service agreements based on the Individual Support Plan. The Oregon ISP has a section that addresses Back-up plans and must be completed for all individuals. Agency based services would be available to individuals no longer self-directing services and the case manager would initiate the established back up plan along with monitoring activities ensures service continuity and participant health and welfare during transitions. (d) the individual and family/legal or designated representative choose which waivered services are important to the individual. They select the waivered services they feel will keep their 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

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 participant's 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 and family/legal or designated representative are informed of their service options when they apply for home and community based services. The individual and family/legal or designated representative are assisted by their Case managers to locate and arrange services, given information and technical assistance to make informed decisions about services and service providers, and assistance to monitor and improve the quality of services. OAR requires the provision of basic information by the CME to individuals prior to the individual and family/legal or designated representative directing services. This information includes requirements for entry, conditions for exit; a description of processes involved in receiving services, including person-centered planning, evaluation, and how to raise and resolve concerns about services; and an explanation of individual rights to select and direct providers of services authorized through the individual's service plan from among qualified providers. b) Case managers are required to inform the individual and family/legal or designated representative of their grievance and appeal rights. This information is provided both orally and in writing to participants. c) This information is provided prior to receiving participant directed services, during development of the initial ISP, during the annual review of the ISP and at any time information is requested by the participant. Case managers may provide additional information as necessary. d) Budget authority information is provided by the case manager and includes a requirement that the individual and family/legal or designated representative provide the case manager with information about how the service meets both an identified need and meets the criteria for provision of Individual Directed Goods and Services. The individual and family/legal or designated representative provide cost estimates for the service and will provide estimates from at least three vendors if requested by the case manager or ODHS. Each Case manager provides or arranges for the individual and their family information on employer related supports for those directing Supported Employment - Individual Employment Support (Job Coaching): ~ Information on what it means to be an employer including employer responsibilities and risks associated with hiring and firing employees and potential risks related to employer insurance liabilities. ~ Websites for Bureau of Labor and Industries (BOLI) information. ~ Use of common employer-related tools such as job descriptions.

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.

Waiver Service	Employer Authority	Budget Authority
Individual Directed Goods and Services	☐	☒

Waiver Service	Employer Authority	Budget Authority
Supported Employment - Individual Employment Support	☒	☐

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*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Fiscal intermediaries perform these services on behalf of the participant when participant direction is chosen: processing payroll, withholding Federal, state, and local tax and making tax payments to appropriate tax authorities, and issuing union dues to an employee union, if applicable.
Oregon uses the RFP process based on the Office of Contracts & Procurements rules to procure a FMS entity. It is an open and competitive process.

Case Management entities are specifically responsible for providing financial management for those with budget authority.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS costs are a set cost per contract negotiation. The FMS contractor is paid a monthly fee for each month they issue a payment to a PSW provider for an individual. The state is charged only one cost per month, per individual regardless of the number of providers being paid for providing services to the individual in that month.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [ ] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [ ] **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

ODHS monitors and assesses the performance of FMS entities in the following ways: • Annual Field Reviews conducted by ODHS staff that review a statistically valid number of participant files including all fiscal and financial records. Claims are reviewed for being allowed under the waiver and Oregon Administrative rule, prior authorization in the Individual Support Plan and whether claims are accurately and appropriately assigned and reported. • All claims are billed by the provider or by the state upon receipt of an authorized time sheet in the eXPRS payment system. • The Department of Human Resources (ODHS) Audit & Consulting Services Division conducts periodic reviews of programs administered by ODHS.

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
Waiver Case Management	☒
Discovery/Career Exploration Services	☐
Employment Path Services	☐
Family Training	☐
Supported Employment - Small Group Employment Support	☐
Specialized Medical Supplies	☐
Vehicle Modifications	☐
Individual Directed Goods and Services	☐
Supported Employment - Individual Employment Support	☐
Environmental Safety Modifications	☐

☐ **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:

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

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:

A participant and family/legal or designated representative who voluntarily terminate their self-directed services are counseled by their Case managers about other service options. The Oregon ISP has a section that addresses Back-up plans and must be completed for all individuals. Agency based services would be available to individuals no longer self-directing services and the case manager would initiate the established back up plan along with monitoring activities ensures service continuity and participant health and welfare during transitions.

Appendix E: Participant Direction of Services

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 provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination from Participant Direction of Services may occur under any circumstance where budgeted funds are used inappropriately. Examples include authorization of purchases for goods or services that are experimental or prohibited treatments. If an individual is involuntarily terminated from Participant Direction, the case manager will meet with the individual and family/legal or designated representative and revise the service plan to ensure continuity of services and assure health and safety. Individuals and family/legal or designated representatives who cannot self-direct Individual Directed Goods and Services will not lose waiver eligibility or be required to transition to a different waiver.

Individuals and family/legal or designated representatives may request to access participant directed services by contacting the case manger and requesting a revision of the service plan. The case manager will meet with the individual and family/legal or designated representative to discuss the options and revise the service plan, as needed.

An individual's legal or designated representative may have their employer authority involuntarily terminated when they are unable to meet the responsibilities of being an employer for Individual Employment Support- Job Coaching services as evidenced by such things as: (A) Independent provider complaints; (B) Multiple complaints from an independent provider requiring intervention from the CME; Intervention includes such actions as: (a) A documented review of the employer responsibilities described in OAR 411-330-0065; (b) Training related to employer responsibilities; (c) Corrective action taken as a result of an independent provider filing a complaint with the Department, the Department's designee, or other agency who may receive labor related complaints; (d) Identifying a representative if an individual is not able to meet the employer responsibilities described in OAR 411-330-0065; or (e) Identifying another representative if an individual's current representative is not able to meet the employer responsibilities described in OAR 411-330-0065. (C) Frequent errors on time sheets, or other required documents submitted for payment that results in repeated coaching from the CME; (D) Complaints to Medicaid Fraud involving the individual or the individual's representative; or (E) Documented observation by the CME of services not being delivered as identified in the individual's Individual Support Plan. When employer authority is removed, the identified support needs can be met using services available through this waiver from provider types that do not have an employment relationship with the individual – contractors, certified provider organizations or a general business. Specific providers of these types may be selected from those available by the individual or the individual's legal representative. Participant direction of these providers will be encouraged and allowed to the greatest extent possible. The individual's case manager will revise the previously authorized ISP to assure all support needs formerly met by the employee will be met by the new provider type. If the individual chooses not to utilize the alternate provider types or alternate provider types are unavailable, the individual or the individual's legal representative will be advised of options for meeting identified needs through other home and community based services that are not available through this waiver. Individual's will be informed of the opportunity to request a Fair Hearing in accordance with the procedures specified in Appendix F-1.

Appendix E: Participant Direction of Services

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		2
Year 2		2
Year 3		2
Year 4		2
Year 5		2

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.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

The state's method to conduct background checks is the same as Appendix C-2-a

☒ **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**

- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

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:*

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**
- [x] **Determine the amount paid for services within the state's established limits**
- [ ] **Substitute service providers**
- [x] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **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

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.

The participant-directed budget will be based on the actual cost of the individual good and/or service that meets the needs of the participant. The participant or their representative will provide: 1) Information on how the item meets a specific need in the ISP 2) Cost estimates from qualified providers of the item or service. If the item or service is provided by a limited number of providers, a statement of how that specific item or service is the most appropriate to meet the needs of the individual, and any other alternatives explored. 3) The expected outcome of purchasing the item or service. For example, how the item or service will address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: a)the item or services would decrease the need for other Medicaid services; AND/OR b) promote inclusion in the community; AND/OR increase the participant's safety in the home environment; AND c) the participant does not have the funds to purchase the item or service or the item or service is not available through another source. 4) The item is not experimental or prohibited. A Notice of Planned Action is sent to individuals for denial of budget amounts. The Notice of Planned Action includes Medicaid fair hearing rights. Disputes may arise out of a denial of a specific amount requested and will be communicated to individuals through the Notice of Planned Action. Oregon has an established assessment and ISP person centered planning process that is applied statewide as well as ODDS expenditure guidelines that are utilized by all case managers to ensure that cost estimating techniques are applied consistently to each waiver participant. The ISP person centered planning process is outlined in the waiver, which is included with each public notice. In addition, Rule Advisory Committees for relevant program rules, and the associated expenditure guidelines, are posted on line.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

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.

Case managers inform the individual and family/legal or designated representative
of the budget amount during the development of the ISP. The budget amount
is determined by the actual cost of the item or service requested.
The individual and family/legal or designated representative
may adjust the amount of the budget by providing cost estimates from service providers, along with a statement indicating how the item or service best meets the needs as described in the ISP.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

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

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:

Individual directed goods and services are budgeted and paid at the actual cost of the item or service. Participant budget authority does not allow underutilization or premature depletion of the participant-directed budget. Case managers ensure safeguards are implemented. Concerns with IDGS Expenditures and updates and the status of authorized IDGS are reviewed with the family during regularly occurring case management contacts.

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.

ODHS has implemented procedures to inform individuals of their right to request a Fair Hearing upon application, at the initial Level of Care (LOC), every 12 months during the Individual Support Plan (ISP) meeting and upon request, by providing the FACT sheet (SDS 0948). The individual or their guardian signs the Notification of Rights document (form SDS 0949) documenting that they have been informed of their right to a file a complaint or request a hearing.
The Department has implemented rules that require anytime an individual's benefits/services are denied, terminated, suspended or reduced they will be given timely, written notice and advised of their fair hearing rights by receiving a Notification of Planned Action (form SDS 0947). The Notification of Planned Action includes the reason for the decision or action, the statute and rules relied upon in making the decision, the records used to make the decision, the manner in which to request a hearing and how to request continuing services as well as the individual's right to due process via a fair hearing. Decision notices must be mailed at least 10 days prior to the action being taken, per Oregon Administrative Rule Chapter 461 Division 175.
Form SDS0422DD, the Office of Developmental Disability Services Administrative Hearing Request, included with all notices of planned actions, contains the question, "Do you want your services to stay the same (not reduced or stopped) while you wait for a hearing?". From there, they are referred to another part of the form that explains continuing services. If the individual misses the deadline for requesting continuing services a request can still be made and ODHS will determine if there is good cause for the late request for continued services. The individual records their preference on the hearing referral form (SDS 0443 DD) with the understanding that they may be liable for the costs of services received if the hearing decision is unfavorable to them.
Upon receipt of a Notification of Planned Action or if the case management entity failed to make a timely decision, the individual and family/legal or designated representative
may request a Fair Hearing. The request for a Fair Hearing is made by completing the Administrative Hearing Request form (SDS 0443DD) and submitting the form to the case management entity or ODHS, or making an oral request for a hearing to either
the case management entity or the Department. If a request for a hearing is made orally by
the individual and family/legal or designated representative, the case management entity which receives the request for hearing must complete the Administrative Hearing Request form (SDS 0443DD) and submit the form to the Department. ODDS also has a website that informs individuals and families about the Administrative Hearings process,
includes a link to the request form, and allows people to contact ODDS directly.
The ODHS lay representative facilitates an informal phone conference between the individual or their representative and the Department. The informal conference is an opportunity to provide the individual or their representative the opportunity to question the planned action and to present additional information if applicable.
Upon receipt of an Administrative Hearing Request form (SDS 0443DD), the Department reviews the hearing request and obtains a copy of the records that were used in the decision to deny, reduce, suspend or terminate the benefit or service. The Department acts as the liaison between the case management entity, the ODHS lay representatives and OAH. The Department is responsible for referring the hearing request to the ODHS lay representative, who reviews both the Notification of Planned Action
(SDS 0947) that was sent to the individual and the request for the hearing (SDS 0443DD). The ODHS lay representatives are

centralized and not part of any local office that determines benefits, services, or eligibility. Hearings are held by the Office of Administrative Hearings, which is independent from the Oregon Department of Human Services.
The ODHS lay representative facilitates an informal phone conference between the individual or their representative and the Department. The informal conference is an opportunity to provide the individual or their representative the opportunity to question the planned action and to present additional information if applicable.
For all hearings that are held before an Administrative Law Judge, the individual or their representative is sent a Notice of Hearing by the OAH with a date and time for a hearing. All hearings are held over the phone unless the individual or their representative requests to have the hearing in person. The outcome of the hearing results in a Proposed Order, Proposed or Final Order, or Final Order that is issued by the OAH. If a Proposed Order is issued, the Department issues a Final Order after 21 days if no written exceptions are filed.
If the individual or their representative disagrees with the Final Order the individual or their representative may appeal the final order by filing a petition in the Oregon Court of Appeals.
The Department maintains a database and tracks each phase of the hearings and the outcome(s) for each hearing. Additionally, the Department maintains a file of all records relied upon during the hearing. A copy of the hearing request and Final Order is sent to the case management entity upon completion of the hearing.
All applicants and recipients of Department programs that require written materials in alternative formats or in their native language are accommodated as well as individuals that require translation or interpreter services. The assistance relies on professional translators/interpreters or services such as Language Lines, ASL, TTY. Other forms of augmentative and/or alternative communication are also options for these individuals.

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**

b. 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**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Oregon Department of Human Services

c. 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).

Oregon Administrative Rule governs Oregon's complaint process.
Complaints may be filed with several entities including:
(A) Complaints regarding dissatisfaction with the services of a provider organization may be filed directly with the provider organization, with the individual's CME, or with the Department.
(B) Complaints regarding dissatisfaction with the services of a CME may be filed directly with the CME, or with the Department.
(C) Complaints regarding dissatisfaction with the Department must be filed with the Department.
A complaint is an expression of dissatisfaction with services or service providers. The CME is required to inform individuals or the individual's representatives of their right to file a complaint upon start of services, every 12 months thereafter,
and upon request by providing a Fact Sheet about Complaints. The fact sheet explains the process of how to file a complaint and response expectations by the CME and ODHS.
filing a grievance or complaint is not a prerequisite or substitute for a fair hearing.
The CME is required to address all complaints made by individuals or the individual's legal or designated representative in accordance with their policies and procedures and the OAR Chapter 411, Division 318.

ODHS and local case management entities must screen all complaints they receive for potential hearings related issues and issue a Fair Hearing Notice when appropriate. Complaints regarding dissatisfaction with services or service providers can be made verbally, in writing or on the ODHS Complaint form (SDS 0946) and be submitted to the CME directly or to ODHS. ODDS also has a website that informs individuals and families about the complaints process, includes a link to the complaint form, and allows people to contact ODDS directly.
There are defined timelines the CME has for responding to complaints, which are:
~ The CME must acknowledge receipt of the complaint within 5 working days.
~The CME must offer the individual the opportunity to participate in an information discussion about the complaint. This informal discussion must occur within 10 working days of the acknowledgement.
~ If a resolution is reached during the informal conference discussion, the CME must provide a written description of the resolution to the individual or the individual's representative within 10 working days of the informal discussion.
~ If a resolution was not reached during the informal conference discussion, the CME must complete a review of the complaint and issue a written outcome within 30 calendar days of the receipt of the complaint, unless both parties mutually agree to another 30 calendar day extension.
The written outcome must include; the rationale for the outcome, cite documents or other information relied on in deciding the outcome, information about the individual or the individual's representative's right to review the relied upon documentation and the process for appealing to ODHS, the CME's written outcome.
The individual or the individual's representative has the right to appeal to ODHS, the CMEs written outcome within 30 calendar days of receiving the written outcome. ODHS also has the same time frames associated as listed above in responding to complaints and appeals and providing the individual or the individual's representative the right to review the documents relied upon in resolving the complaint or appeal. ODHS has a complaint tracking database which has the capability to consistently track all complaints that are not resolved at the CME level. The complaint database is utilized to track whether the complaint process is timely, identify any potential trends across the services system geographically or statewide, as well as contributing to Quality Assurance/Quality Improvement activities.

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).

Case managers and service providers are mandatory reporters of child abuse, neglect and exploitation. Individuals that are required to report are defined in ORS 419B.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 case managers and the service providers are mandatory reporters.

Case managers and service providers are required to immediately report to the child abuse hotline, when they have reasonable cause to believe that any child with whom they come in contact has suffered abuse or that any person with whom the case manager or service provider comes in contact has abused a child in the manner described in ORS 419B.010 and ORS 419B.015, and the police if there is reason to suspect a crime has occurred.

The state of Oregon has a cross-reporting statute (ORS419B.015) for suspected child abuse that applies to ODHS and law enforcement entities. The statute requires ODHS child welfare and law enforcement to cross report to each other within specified time frames bases on assessed level of risk.

Case managers requests families to inform them of all incidents, but because these children live in their family's home, the case manager is not always informed when an incident occurs. Additionally, a provider must immediately notify the parent and, if appropriate, the case manager, of injury, illness, accidents, or any unusual circumstances that may have a serious effect on the health, safety, physical, emotional wellbeing, or level of service required by the child for whom services are being provided.

Case managers are also mandatory reporters of Medicaid fraud. Reports of suspected fraud are made immediately to the ODHS Fraud Unit. Should investigations occur as a result of a report of abuse or fraud, case managers cooperate with the investigation and incorporate recommendations into any subsequent service plans of care.

All case managers are required to report critical incidents, known as serious incidents, and make reports of suspected abuse, neglect and exploitation across all types of ODHS services. Serious incidents and abuse are defined in OAR 411-317-0000. Reporting 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 as follows:

CASE MANAGEMENT SERVICES FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES
411-415-0055 Abuse and Serious Incident Management
411-415-0080 Accessing Developmental Disabilities Services
411-415-0090 Case Management Contact and Monitoring of Services

ODHS maintains a secure, web-based system, for identification and follow up tracking of abuse and serious incidents. CME staff enter incidents into the web-based incident management system. Utilization of the ODHS incident management system is mandatory.

A serious Incidents is:
(a) An act of physical aggression by an individual resulting in injury.
(b) Death of an individual
(c) An individual receives emergency medical care
(d) An emergency physical restraint is used
(e) An individual is missing beyond the timeframe established in the ISP
(f) Admission to a psychiatric hospital
(g) A safeguarding intervention or the use of safeguarding equipment results in injury to the individual
(h) An individual attempts suicide
(i) An unplanned hospitalization
(j) A medication error with adverse consequence.

Incident reports are required for any allegation of abuse, and serious incident. Agency Providers may report serious incidents by phone, in-person, email, writing, or verbally and maintain confidentiality, and must provide a written report for serious incidents.

PSWs and family members may report serious incidents by phone, in-person, email, writing, or verbally.

Central Office staff review incidents and related follow up data on a regular basis to identify emerging trends.

Local Incident Management teams made up of case managers, Program 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 this waiver live in their family home where the services are delivered. The parents or their legal guardians are ultimately responsible for the care and safety of the child. Even though Case managers oversee the appropriateness and safety of the waiver services, the Case managers may not be notified by the family of each incident listed above.

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 case manager at the time of enrollment, and every 12 months thereafter at ISP renewal and ongoing during ISP implementation, based on need and family request. When the initial ISP is
developed with the family, the case manager provides direct, face to face training and information about waiver services and reporting abuse, neglect and exploitation. ODHS maintains extensive online and printed materials on how to report abuse and neglect of children and adults. In the case of an emergency, as defined by ODDS, the face to face requirement may be waived.
Families are informed by their case manager that all case managers 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 case manager whenever concerns arise.

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, neglect and exploitation are reported by any concerned party to the child abuse hot line and the police if there is reason to suspect a crime has occurred. All reports of suspected child abuse and neglect are cross-reported according to statute 419B.015 between ODHS and law enforcement. ODHS 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 ODHS administrative rule 413-015-0300 to 0310.

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 within 24 hours or five days depending on the nature of the allegation, or a child is at immediate risk. The length of time for an assessment 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. Child Welfare investigators typically interview family members, including all children, alleged perpetrators, and make contact with other agencies involved with a family that is under investigation.

Case managers assist with information about the child's disabilities and functioning level, the family situation and ODHS services as requested by the investigator. Child Welfare, depending on the nature and outcome of the investigation, may involve case managers in developing recommendations and determining follow up actions, though it is not a requirement in statute and rule. Child Welfare or law enforcement inform the family of the outcome of the investigation. Oregon Administrative Rule 413-015-0470 describes the process and timeframes for informing the participant, (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, the waiver operating agency) of the investigation results. Case managers 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 CME staff directly to the ODHS Medicaid Fraud Unit or the ODHS Provider Fraud Unit, depending on the allegation. Any concerned party may report fraud to the CME or to the ODHS Fraud Units. Case managers inform families and providers if they make a report of suspected fraud. Incidents of suspected fraud that could endanger a child and also be suspected child abuse are reported by the case manager to ODHS Child Welfare. Investigations occur by ODHS staff employed in one of those Units. The ODHS Fraud Unit informs the subject and the CME of the outcome of the investigation. The CME 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.

A serious incident must be entered into the web-based incident management system within seven days of receiving the report of the incident. The incident must be closed in the system not more than 30 days after it is entered. An incident is considered closed after the case manager has evaluated the incident and provided recommended action to the parties responsible for maintaining the health and safety of the individual that will mitigate future, similar serious incidents, if any are indicated. If there are concerns regarding Serious Incidents involving provider agencies where the serious incident(s) is egregious, there are multiple serious incidents, or there are other concerns regarding health and safety, licensing staff investigate the concerns and take action accordingly. There is no formal requirement to inform the participant of the case management entity’s or provider’s response to the serious incident.

Serious incidents entered into the incident management system (described in G-1-b) that are not directly related to abuse investigations or client or provider fraud are also included in the ongoing monitoring responsibilities of the case manager and the general oversight of the waivers. Reports and entries of serious incidents are based on case manager observation and information from families and providers. Case managers 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 case manager, entries in the incident management system are reviewed quarterly by an incident management team consisting of case managers, 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. Case managers 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. ODDS Management and administrative staff participate on ODHS statewide groups to determine if emerging trends and potential responses overlap with other DD Program service elements, geographic indicators or training initiatives 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.

ODHS Child Welfare is responsible to oversee all reporting, investigation, and response to child abuse and neglect for all of Oregon's children.
Child Welfare trains Child Welfare investigators and keeps an electronic and paper record of all allegations of abuse and the outcome.
Case managers give information to families and providers on their responsibility as mandatory reporters and how to make reports of child abuse and neglect.
ODHS, ODDS has the responsibility to oversee the response to incidents or unusual incidents for children in the MFW whether or not the incidents lead to an allegation of abuse or neglect. CME staff make entries into the online incident management system
system as described in G-1-b and G-1-c. All incidents entered into the online incident management system are reviewed on a regular basis
for emerging trends and patterns of concern and to determine what response is needed for the CME and system wide.
ODHS, ODDS Quality Assurance staff compile, review and analyze performance data through electronic file reviews and data reports once every two years. Corrective action/remediation plans are submitted to CMEs as areas of improvement are identified.
Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. Central office staff follow-up to ensure appropriate action is taken. A statewide report documenting key performance measures and remediation outcomes is provided to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC reviews annual reports on key performance measures to ensure follow-up and compliance.
The MOCSC will review statewide reports that includes statistics, performance measures, and follow-up activities for incidents for all populations served under the waiver, including licensing, adult protective services,. Where additional information or clarification is needed, the MOCSC will ask ODHS to provide it. The MOCSC will have access to all supporting databases.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints 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. 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). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Restraints may only be applied in emergency situations where there is imminent risk of serious harm to the individual or others. The restraint may only be applied for as long as the threat remains critical and only when there are no less restrictive alternative methods of mitigating risk available.
When the need for a restraint in an emergency is anticipated (based on past events, condition, and nature and intensity of risks), then the individual is afforded the opportunity to engage in the Individually-Based Limitations (IBL) process and provide consent for the protective measures to be included in the person-centered service plan. The IBL process is part of the person-centered service planning which address proposed modifications to HCBS protections, including the freedom from restraint.
Restraints (referred to as Safeguarding Interventions), when indicated, must be part of a positive behavior support plan and included in the person-centered service plan, and must be directed by a medical professional or qualified Behavior Professional. The maneuver must be compliant with ODDS approved curriculum.
OAR 411-415-0070(3)(d)(A)(B) Service Planning:
(3) INDIVIDUALLY-BASED LIMITATIONS.
(d) An individually-based limitation must only include a safeguarding intervention that --
(A) Meets the definition found in OAR 411-317-0000 and complies with OAR 411-304-0150, OAR 411-304-0160, and applicable program rules.
(B) When used to address a challenging behavior, is directed in a Positive Behavior Support Plan written by a behavior professional qualified to author the safeguarding intervention according to ODDS approved behavior intervention curriculum and certification as described in OAR 411-304-0150.
411-004-0040 (3)
Individually-Based Limitations
(3) An individually-based limitation must be supported by a specific assessed need and documented in the person-centered service plan by completing and signing a program approved form documenting the consent to the appropriate individually-based limitation. The form identifies and documents, at minimum, all of the following requirements:
(a) The specific and individualized assessed need justifying the individually-based limitation.

(b) The positive interventions and supports used prior to any individually-based limitation.
(c) Less intrusive methods that have been tried but did not work.
(d) A clear description of the limitation that is directly proportionate to the specific assessed need.
(e) Regular collection and review of data to measure the ongoing effectiveness of the individually-based limitation.
(f) Established time limits for periodic reviews of the individually-based limitation to determine if the limitation should be terminated or remains necessary. The individually-based limitation must be reviewed at least annually.
(g) The informed consent of the individual or, as applicable, the legal representative of the individual, including any discrepancy between the wishes of the individual and the consent of the legal representative.
(h) An assurance that the interventions and support do not cause harm to the individual.
(i) For restraints, there is a physician or other qualified practitioner order for the use of restraint. Individual licensing authorities may adopt stricter criteria regarding the use of restraints.
Paid care providers applying the maneuver must be trained in fundamentals of behavior support intervention and be specifically trained to apply the maneuvers to the individual. Data collection, reporting and monitoring are identified as a component of the IBL.
When restraints are applied in an emergency and are not included in an IBL, the paid provider applying the restraint must report the event to the case management entity. If there are more than three emergency applications of a physical intervention not addressed in a person-centered service plan, the planning team must meet to determine if formal behaviors support services are necessary.
Restraints are never permitted based on provider convenience or as a punitive measure.
Restraints may not include any of the following characteristics: abusive, aversive, coercive, disciplinary, demeaning, pain compliance, prone restraints, punishment, and supine restraints.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

ODDS is responsible for quality assurance monitoring of plans that include the use of restraints.
The quality assurance staff compile, review and analyze performance data through CME reviews, electronic file reviews and data reports for reviews that occur every two years. The quality assurance staff's analysis of the performance data asks three questions: 1) Did the CME meet the required compliance rate for each question related to the areas of Health and Welfare, to include IBLs
(Modifications to Conditions), and Monitoring; 2) What case specific and/or systemic corrective action is required to bring the CME into compliance; and 3) Are there immediate health and safety risks/concerns that need to be addressed. Corrective action/remediation plans are submitted to CMEs as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. ODDS staff follow-up with CMEs to ensure appropriate action is taken.
In order for a restraint to be authorized, the use of the restraint must be directed by a medical practitioner in a medical order or by a behavior professional in a Positive Behavior Support Plan (PBSP). Restraints identified in an individual's plan may only be applied by a caregiver who has been properly trained specific to the individual and in accordance with ODDS-approved curriculum on the application of the technique or equipment.
Each use of restraint applied in an emergency and not included in an IBL must be documented and reported to the case management entity. The case manager must then review the incident report and take appropriate follow up action.
Anyone can make reports of complaints regarding unauthorized use of restraints. Restraints that are unauthorized may be considered abuse.
All providers of ODDS HCBS services are considered mandatory reporters and must make report of any suspected abuse, including the use of unauthorized restraints.
ODDS has also adopted a formal complaints process which allows for the receipt of complaints from individuals or on behalf of individuals. The complaints may be received by the CME and must be logged and reported to ODDS. Individuals may file a complaint directly with ODDS. Individuals must be notified of their right to make complaints on at least an annual basis. Individuals are entitled to assistance as needed and desired to support their ability to make reports.
Additionally, Oregon has documentation requirements which also help to identify if there are issues with the application of interventions. Whenever a restraint is applied, the event must be documented by the service provider and submitted to the case management entity. If the emergency use of a restraint is applied more than three times in a six-month period, the case manager must evaluate and address if there is a need for professional behavior services and/or an Individually-Based Limitation (Modifications to Condition).
ODDS communicates information and findings to the Medicaid Agency, OHA by email to the designated OHA staff as well as through joint ODHS/OHA oversight committees. The ODHS/OHA oversight committee meets at least twice a year to review quality assurance overview reports. ODHS staff also address individual problems with designated OHA staff on an ongoing basis. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving ODHS reports, documents, rules, policies and guidelines. OHA, on a continuous and ongoing basis, reviews and provides input to ODHS quality control processes for Medicaid/CHIP programs managed by the ODHS to assure proper oversight of central office and field operations. This includes ongoing review and approval of ODHS operational oversight and quality assurance activities. As designated OHA staff and the ODHS/OHA oversight committee receive reports of findings and remediation efforts, it informs the Medicaid Director and the Medicaid Operations Coordination Steering Committee thus informing executive management of OHA and ODHS.

ODHS will conduct quarterly system's improvement meetings to review and analyze indicators of success related to the current ODDS strategic plan. Participant feedback on system-wide data and trends will be used to develop and prioritize strategies that lead to the implementation of system improvements. Meeting participants will include representatives from a broad stakeholder base, which includes people receiving services, family members, service providers, case management representatives, ODDS representatives and others determined appropriate or invited by the ODDS Director or designee.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

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 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.

Restrictive interventions may only be used when based on an individual-specific need to address critical health and safety risks. Restrictive interventions must be person-centered and may only be used when there is no less restrictive alternative to address a current significant health and safety risk specific to the individual and their situation and may only be used as long as the significant risk is imminent.. Restrictive interventions may be employed to support individuals to comply with legal mandates, conditional releases, and to maintain safety.
The specific types of restrictive interventions that are permitted are individual-specific dependent upon nature and severity of risk. The use of restraint interventions are primarily reactive strategies and must be directed by a medical or behavior professional, dependent on the nature of the risk or condition presented.
Although the restrictive interventions are individualized, there are specific restrictions on interventions. Interventions used must not be abusive, aversive, coercive, for convenience, disciplinary, demeaning, prone or supine restraints, pain compliance, punishment, or retaliatory. Interventions cannot

be provider or setting driven. Restrictive interventions may only be applied if they are the least restrictive method for addressing the identified risk and consent to by the individual. Practices that result in involuntary seclusion or isolation of an individual are not permitted.
Restrictive interventions which include the use of restraints by a paid caregiver apply in any setting. See "The use of restraints is permitted during the course of the delivery of waiver services under items G-2-a-i and G-2-a-ii".
All restrictive interventions will be included in the person-centered service plan.
Restrictive intervention are never permitted based on paid provider convenience or as a punitive measure. Restrictive interventions must not have the following characteristics: abusive, aversive, coercive, disciplinary, demeaning, pain compliance, punishment, or seclusionary.
Case managers authorize the use of restrictive interventions with qualifications as indicated in Appendix C of the waiver which include:
Each case manager must have knowledge of the public service system for developmental disabilities services in Oregon and at least:
~ A bachelor's degree in behavioral science, social science, or a closely related field; or
~ A bachelor's degree in any field AND one year of human services related experience; or
~ An associate's degree in a behavioral science, social science, or a closely related field AND two years human services related experience; or
~ Three years of human services related experience.
Agency, licensed, certified, endorsed, and independent providers must all have the ability to provide services adequate meet the health and safety needs of the individual. This ability includes knowledge and understanding of behavior support strategies specific to the individual. Providers must implement support strategies in accordance with the authorized Individually-Based Limitation which identifies the restrictive interventions appropriate to the individual. If restraints are an identified support strategy, then the providers must have training in ODDS-approved curriculum and have training specific to the individual in the appropriate application of intervention techniques.
OAR 411-004-0040
Individually-Based Limitations
(3) An individually-based limitation must be supported by a specific assessed need and documented in the person-centered service plan by completing and signing a program approved form documenting the consent to the appropriate individually-based limitation. The form identifies and documents, at minimum, all of the following requirements:
(a) The specific and individualized assessed need justifying the individually-based limitation.
(b) The positive interventions and supports used prior to any individually-based limitation.
(c) Less intrusive methods that have been tried but did not work.
(d) A clear description of the limitation that is directly proportionate to the specific assessed need.
(e) Regular collection and review of data to measure the ongoing effectiveness of the individually-based limitation.
(f) Established time limits for periodic reviews of the individually-based limitation to determine if the limitation should be terminated or remains necessary. The individually-based limitation must be reviewed at least annually.
(g) The informed consent of the individual or, as applicable, the legal representative of the individual, including any discrepancy between the wishes of the individual and the consent of the legal representative.

(h) An assurance that the interventions and support do not cause harm to the individual.
(i) For restraints, there is a physician or other qualified practitioner order for the use of restraint. Individual licensing authorities may adopt stricter criteria regarding the use of restraints.

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:

ODDS is responsible for quality assurance monitoring of plans that include the use of restrictive intervention.
Quality assurance staff compile, review and analyze performance data through CME reviews, electronic file reviews and data reports. The quality assurance staff's analysis of the performance data asks three questions: 1) Did the CME meet the required compliance rate for each question related to the areas of Health and Welfare, to include IBLs (Modifications to Conditions), and Monitoring; 2) What case specific and/or systemic corrective action is required to bring the CME into compliance; and 3) Are there immediate health and safety risks/concerns that need to be addressed. Corrective action/remediation plans are submitted to CMEs as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. ODDS staff follow-up with CMEs to ensure appropriate action is taken.
ODDS communicates information and findings to the Medicaid Agency, OHA by email to the designated OHA staff as well as through joint ODHS/OHA oversight committees. The ODDS QA reviews occur every two years. The ODHS/OHA oversight committee meets at least twice a year to review quality assurance overview reports. ODHS staff also address individual problems with designated OHA staff on an ongoing basis. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving ODHS reports, documents, rules, policies and guidelines. OHA, on a continuous and ongoing basis, reviews and provides input to ODHS quality control processes for Medicaid/CHIP programs managed by the ODHS to assure proper oversight of central office and field operations. This includes ongoing review and approval of ODHS operational oversight and quality assurance activities. As designated OHA staff and the ODHS/OHA oversight committee receive reports of findings and remediation efforts, it informs the Medicaid Director and the Medicaid Operations Coordination Steering Committee thus informing executive management of OHA and ODHS.
Each use of restraint, unusual events, and incidents of significant injury to the individual must be documented and reported to the case management entity. The case manager must then review the incident report and take appropriate follow up action.
Anyone may make reports of complaints regarding unauthorized restrictive interventions. Restrictive interventions that are unauthorized may be considered abuse. All providers of ODDS HCBS services are considered mandatory reporters and must make report of any suspected abuse, including the use of unauthorized restrictive interventions.
ODDS has also adopted a formal complaints process which allows for the receipt of complaints from individuals or on behalf of individuals. The complaints may be received locally by the case management entity (CME) and must be logged and reported to ODDS. Individuals may file a complaint directly with ODDS. The source of complaints can be from anywhere and, in most cases, will be responded to by the CME. ODDS and its designees may also partner with other community resources or groups, including protective services to identify and resolve issues.
Individuals must be notified of their right to make complaints on at least an annual basis. Individuals are entitled to assistance as needed and desired to support their ability to make reports.
Additionally, Oregon has documentation requirements which also help to identify if there are issues with the application of interventions. Whenever a restraint is applied, the event must be documented by the service provider and submitted to the case management entity. If the emergency use of a restraint is applied more than three times in a six month period, the case manager must evaluate and address if there is a need for professional behavior services and/or an Individually-Based Limitation. These documentation requirements allow for tracking and reporting should there be a need to address situations where unauthorized or inappropriate restrictive interventions have been utilized.
The use of restrictive interventions is authorized by the individual's case manager. The intervention may only be authorized once the Individually-Based Limitations (IBL) (Modifications to Conditions) process has been applied. The IBL process is a part of the person-centered planning process which engages the individual in identifying safety risks and strategies to address the risk specific to the individual.
The IBL process results in the completion of the CMS documentation requirements for a Modification to the Condition of HCBS freedoms. The process includes identification of the risk, a description of the intervention, less restrictive measures that were tried but did not work, alternative strategies considered, a plan for monitoring the effectiveness of the limitation, established timelines for review, and consent by

the individual (or their legal representative, as applicable). If all of the required information is present, including verification that the intervention is the least restrictive, most appropriate option for addressing the individual-specific health and safety risk and the individual consents, the case manager may authorize the restriction. The documentation is included in the Individual Support Plan (ISP).
Some individuals may have treatment plans developed by other professional providers who support the individual in services outside of ODDS HCBS services. The individual's HCBS provider may help the individual follow recommended treatment plans, but interventions must be consented to by the individual and represent the most appropriate, least restrictive measures for addressing risk.
The use of restrictive interventions is monitored by the case manager in accordance with the individualized plan included in the ISP specific to the limitation. Some interventions will have frequent monitoring while others may be evaluated and authorized every 12 months at a minimum.
Additionally, ODDS Quality Assurance also conducts a sample review of ISPs which includes identifying if IBLs are in place and implemented in accordance with administrative rule and as described in ISPs.
ODDS requires that the CMS documentation requirements for Modification to the Conditions (IBLs in Oregon) be included in the ISP. Currently, ODDS utilizes a specific form which walks the case management entity through all of the CMS documentation requirements including: identification of the risk, a description of the intervention, less restrictive measures that were tried but did not work, alternative strategies considered, a plan for monitoring the effectiveness of the limitation, established timelines for review, and consent by the individual (or their legal representative, as applicable). If all of the required information is present, including verification that the intervention is the least restrictive, most appropriate option for addressing the individual-specific health and safety risk and the individual consents, the case manager may authorize the restriction. The documentation is then attached to and included in the ISP.
As part of the documentation process, the person-centered planning team must identify a plan for measuring the effectiveness of the intervention. This includes a plan for data collection, documentation, and tracking when interventions are implemented. The data tracking is highly customizable to be individual specific, dependent on the nature of the intervention, and to promote efficiency in the delivery of support to individuals.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The children enrolled in the MFC waiver are served in their family home. Their ISPs do not include the use of seclusion. Case managers who oversee the ISP and the services delivered
in the home report any use of seclusion through the online incident management system. If harm is caused or there is a
threat of harm, a report of child abuse is made to the child abuse hotline and the police if there is reason to suspect a crime has occurred. Case
managers through 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 seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of 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 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-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)*

b. 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.

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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)*

ii. 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).

iii. 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:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

○ **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:

iv. 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.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
PM27: Number and percent of waiver participants and/or guardians who are informed about the ways to identify and report abuse, neglect and exploitation.
Numerator: Number of waiver participants and/or guardians who are informed about the ways in which to identify and report abuse, neglect and exploitation.
Denominator: Total number of waiver participants reviewed.

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

Performance Measure:
PM26: Number of participants with incidents of abuse (as defined in OAR/ORS) remediated according to ODDS policy. N: Number of participants with incidents of abuse (as defined in OAR/ORS) remediated according to ODDS policy. D: Total number of participants reviewed.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify:	

	Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: biennially

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
PM28: Number and percent of waiver participants reviewed with incident reports that were reported timely. N: Number of waiver participants reviewed with incident reports reported timely. D: Total number of waiver participants reviewed with incident reports.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

Performance Measure:
PM29: Number and percent of trends identified, by ODDS, where systemic intervention was implemented N: Number of trends identified, by ODDS, where systemic intervention was implemented during the review period. D: Total number of trends identified during the review period.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
PM30: Number and percent of substantiated cases of wrongful restraint and/or involuntary seclusion remediated according to ODDS policy for waiver participants.
N: Number of substantiated cases of wrongful restraint and/or involuntary seclusion remediated according to ODDS policy for waiver participants. D:Total number of

incidents of wrongful restraint and/or involuntary seclusion.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
PM31: # & % of waiver participants reviewed with a serious risk(s) identified on the Risk Identification Tool (RIT) where there is evidence of the risk addressed in ISP. N: # of waiver participants reviewed with a serious risk(s) identified on the RIT where there is evidence of risk addressed in ISP. D: Total # of waiver participants reviewed.

Data Source (Select one):
Record reviews, on-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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: A random sample of the combined populations of waivers 0565, 40193 & 40194 with confidence interval = 95%/5%/50% to determine sample size.
	☒ **Other** Specify: Biennially	

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Other** Specify: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

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.

The frequency of data collection, aggregation and analysis is biennial with site and file reviews conducted on an ongoing basis with reviews at each site every two years. The sample universe will be comprised of waiver year 1 and 2 for the #40193, #40194 and #0565 waivers combined, to determine the statistically valid representative random sample size. The file review sample size used for all measures in Appendix D and two of the appendix G performance measures is based on a statistically valid representative random sample utilizing a 95% confidence level, 5% margin of error and 50% response distribution, as determined by the Raosoft sample size calculator found at http://www.raosoft.com/samplesize.html for the two-year cycle. This representative sample is proportioned across case management entities based on the percentage of the population served relative to the waiver population size. Half of the sample will be pulled for participants who were enrolled in waiver year one and the other half pulled for participants enrolled in waiver year two. Within the sample drawn each year of the biennial cycle, Oregon will over sample to account for multiple variable review, as well as to account for 'non-response' factors such as participants who are no longer enrolled in the waiver due to relocation out of state or death and participants whose length of enrollment within the review period is insufficient to produce results for the variables measured (e.g., service plan updated annually cannot be assessed for someone who is newly enrolled for less than 12 months).

All other performance measures utilize a 100% review process of the total population for the review period for the unit of analysis of the measure (e.g., waiver participants, providers, claims).

Oregon's sampling methodology is informed by the Sampling Guide included in Attachment D of the 1915c HCBS Waiver Technical Guide Resource Attachments. In particular, this sampling methodology comports with guidance regarding proportionate sampling described on page 24 and oversampling to account for the number of variables to be examined and non-response rate, both described on page 21.

The 0565, 40193 and 40194 waivers meet the following five CMS conditions:
1. Design of the waivers is the same or very similar;
2. This sameness or similarity is determined by comparing waivers on the approved waiver application appendices:
a. Participant Services,
b. Participant Safeguards, and
c. Quality Management;
3. The quality management approach is the same or very similar across waivers, including:
a. Methodology for discovering information (e.g., data systems, sample selection),
b. Manner in which individual issues are remedied,
c. Process for identifying and analyzing patterns/trends, and
d. Majority of the performance indicators are the same;
4. The provider network is the same or very similar; and
5. Provider oversight is the same or very similar."
Data and reports gathered and created by ODHS staff during quality reviews are reviewed and analyzed on a continuous and ongoing basis by designated OHA staff, including the OHA liaison to ODHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Upon completion of OHA' analysis and review of ODHS quality assurance data and reports, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document ODHS and OHA remediation efforts.
The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and ODHS. The MOCSC meets at least quarterly to coordinate and review all mutual policy issues related to the operation and administration of the Medicaid/CHIP program including state plan amendments, waiver requests, rules, procedures, and interpretive guidance. A Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) for OHA and ODHS meets at least twice per year to review Medicaid/CHIP-related policy. The Steering Committee is comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of policy-related issues and delineation of responsibilities, including establishment of a strategic plan for the two agencies.

ODHS staff address individual problems with designated OHA staff on an ongoing basis and during regularly scheduled meetings. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving ODHS reports, documents, rules, policies and guidelines. OHA, on a continuous and ongoing basis, reviews and provides input to ODHS quality control processes for Medicaid/CHIP programs managed by the ODHS to assure proper oversight of central office and field operations. This includes ongoing review and approval of ODHS operational oversight and quality assurance activities.
As designated OHA staff, the OHA liaison, and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Joint Policy and Operations Steering Committee outlined above, thus informing executive management of OHA and ODHS.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Individual remediation activities will require follow-up by the ODHS Quality Management
Staff to determine that the corrective action was successfully completed by the field office, licensing or abuse investigation unit. The results of any remediation will be submitted to an inter-departmental workgroup for discussion, data collection and reporting. When individual and/or system-wide remediation activities are warranted based on discovery and analysis, the following time frames will be used to ensure these items are remediated in a timely manner. Because ODHS is monitoring the performance of its contractors (CMEs, and service providers)
Non-compliance will be determined by any performance measure that falls below 86% accuracy.
ODHS timelines for remediation:
Corrective Action Plans: Within 45 days of Department’s identification of need for plan of correction, entities reviewed must submit a plan of correction.
Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 45 days of Department’s approval of entity’s plan of correction.
Completion of corrective actions: Within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff).
Timelines for systemic remediation:
Required system-wide changes: If changes require revision of administrative rules, the required changes will be completed within the time frames required by the administrative rule process, including Rule Advisory Committees (including stakeholder input), Administrative rule hearings and statutory filing time frames. If system-wide changes require waiver amendments, the process will be completed at the time of approval of the waiver amendment. This will include the 30 day public and 60 day tribal input period and 90 day approval process.
Follow-up to determine effectiveness of remediation activities will occur during the next discovery and review cycle using a comparison of compliance level pre- and post-remediation to determine the level of success with the remediation activity. After initial remediation is completed a follow-up will occur within 180 days to determine the effectiveness of the method. If additional remediation is required, it will be added to the corrective action plan.
The Quality Improvement System will ensure that all discovery and remediation activities have a process in place to ensure system improvement. The Oregon Health Authority and Oregon Department of Human Services will
collaborate through inter-departmental meetings to coordinate these activities. These meetings will occur at least quarterly to report on the corrective actions and follow-up required to ensure system improvement.
Remediation strategies include training, revision of administrative processes and procedures, administrative rule revisions and waiver amendments. These strategies will be used based on the results of the discovery and analysis of the related performance measure. If compliance with the performance measure falls below 86%, a request for a corrective action plan, including activities and time lines for completion and follow-up will be required. Follow-up will include a discovery process using a valid random sample. Follow up discovery will be conducted using the standardized survey instruments and methods utilized during the initial discovery phase.

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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: ODHS-Site/file reviews conducted ongoing with on-site reviews every two years OHA-reviews ODHS through regularly scheduled MOCSC meetings to identify trends that may require statewide QIS changes

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 3)

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 QIS 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; and
- 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 OIS* 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 QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

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.

The Oregon Health Authority and Oregon Department of Human Services will utilize performance measures to evaluate all HCBS waivers (0117, 0375, 0565, 40193, 40194, and 0185) as well as the 1915(k) Community-First Choice option. Continuous system improvement is the basis of the Quality Improvement System (QIS).
The QIS will utilize discovery, analysis and remediation activities as the method of ensuring that Home and Community-Based Services provided through the waivers and state plan are monitored and that necessary corrective action processes are in place. The discovery and analysis phase will occur on a two-year cycle for all Home and Community-Based services authorized under Section 1915(c) and 1915(k) authorities.
Remediation is an ongoing process that will occur during the discovery phase. Individual remediation will occur when corrective action is needed in any one geographic area or field office. System-wide remediation activities will occur every two years, when required, based on statewide discovery and analysis. Both individual and system-wide remediation activities will require a corrective action plan.
The Oregon Health Authority and Oregon Department of Human Services will utilize performance measures to evaluate all HCBS waivers (0117, 0375, 0565, 40193, 40194, and 0185) as well as the 1915(k) Community- First Choice option. Continuous system improvement is the basis of the Quality Improvement System (QIS).
The QIS will utilize discovery, analysis and remediation activities as the method of ensuring that Home and Community-Based Services provided through the waivers and state plan are monitored and that necessary corrective action processes are in place. The discovery and analysis phase will occur on a two-year cycle for all Home and Community-Based services authorized under Section 1915(c) and 1915(k) authorities.
Remediation is an ongoing process that will occur during the discovery phase. Individual remediation will occur when corrective action is needed in any one geographic area or field office. System-wide remediation activities will occur every two years, when required, based on statewide discovery and analysis. Both individual and system-wide remediation activities will require a corrective action plan.
ODHS will conduct quarterly system's improvement meetings to review and analyze indicators of success related to the current ODDS strategic plan. Participant feedback on system-wide data and trends will be used to develop and prioritize strategies that lead to the implementation of system improvements. Meeting participants will include representatives from a broad stakeholder base, which includes people receiving services, family members, service providers, case management representatives, ODDS representatives and others determined appropriate or invited by the ODDS Director or designee.

OHA will review operating agency performance through regularly scheduled MOCSC meetings and will use these meetings to identify trends that may require changes to the overall statewide Quality Improvement Strategy.

Additionally, the MOCSC meets at least quarterly to coordinate and review all mutual policy issues related to the operation and administration of the Medicaid/CHIP program including state plan amendments, waiver requests, rules, procedures, and interpretive guidance. A Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) for OHA and ODHS meets at least twice per year to review Medicaid/CHIP related
policy. The Steering Committee is comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of policy-related issues and delineation of responsibilities, including establishment of a strategic plan for the two agencies.
On an ongoing basis and during regularly scheduled meetings, ODHS and OHA staff addresses individual and systemic issues and remediation efforts. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving ODHS reports, documents, rules, policies and guidelines. OHA, on a continuous and ongoing basis, reviews and provides input to ODHS quality control processes for Medicaid/CHIP programs managed by the ODHS to assure proper oversight of central office and field operations. This includes ongoing review and approval of ODHS operational oversight and quality assurance activities.
As the OHA liaison, system's improvement committee, and the MOCSC receive reports of findings and remediation efforts, it informs
the Medicaid Director and the Steering Committee outlined above, thus informing executive management of OHA and ODHS.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: ODHS File reviews conducted on-site every two years OHA reviews ODHS through regular MOCSC meetings

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.

Staff from ODHS-ODDS, CDDPs, and Brokerages administers all services
delivered through the waiver operated by ODHS- ODDS.
ODDS, CDDPs, Brokerages and CO staff uses 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.
ODDS, CDDPs, Brokerages and CO staff seeks 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.
ODDS, CDDPs, Brokerages and CO staff collects 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. ODHS staff compiles reviews and analyzes
performance data through a variety of file reviews and data reports. Corrective action/remediation plans are required as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods.
ODHS Central Office staff follow-up to ensure appropriate action is taken. A statewide report documenting key performance measures and remediation outcomes is provided to the OHA/ODHS liaison, the system's improvement committee , and the Medicaid/CHIP Operations Coordination
Committee (MOCSC). The system's improvement committee and the MOCSC reviews annual reports on key performance measures to ensure follow-up and compliance.

Statewide remediation will occur based on the results of the two-year performance measure discovery and analysis activities. After the two year discovery cycle, analysis of statewide accuracy on all performance measures will be reviewed by OHA and/or ODHS Quality Management staff. If statewide accuracy on any performance measure falls below 86%, a system-wide corrective action plan will be developed.

The frequency of data collection, aggregation and analysis is biennial with site and file reviews conducted on an ongoing basis with reviews at each site every two years. The sample universe will be comprised of waiver year 1 and 2 for the #40193, #40194 and #0565 waivers combined, to determine the statistically valid representative random sample size. The file review sample size used for all measures in Appendix D and two of the appendix G performance measures is based on a statistically valid representative random sample utilizing a 95% confidence level, 5% margin of error and 50% response distribution, as determined by the Raosoft sample size calculator found at http://www.raosoft.com/samplesize.html for the two-year cycle. This representative sample is proportioned across case management entities based on the percentage of the population served relative to the waiver population size. Half of the sample will be pulled for participants who were enrolled in waiver year one and the other half pulled for participants enrolled in waiver year two. Within the sample drawn each year of the biennial cycle, Oregon will over sample to account for multiple variable review, as well as to account for 'non-response' factors such as participants who are no longer enrolled in the waiver due to relocation out of state or death and participants whose length of enrollment within the review period is insufficient to produce results for the variables measured (e.g., service plan updated annually cannot be assessed for someone who is newly enrolled for less than 12 months).

All other performance measures utilize a 100% review process of the total population for the review period for the unit of analysis of the measure (e.g., waiver participants, providers, claims).

Oregon's sampling methodology is informed by the Sampling Guide included in Attachment D of the 1915c HCBS Waiver Technical Guide Resource Attachments. In particular, this sampling methodology comports with guidance regarding proportionate sampling described on page 24 and oversampling to account for the number of variables to be examined and non-response rate, both described on page 21.

These three waivers are administered as one program known as the Children's Intensive In-home Services Program. Therefore, policies
and procedures are consistent across all three waivers as well as waiver services that are available. Participant

safeguards are consistent across all three waivers as well as the quality management program. The provider network is also the same and the provider oversight process is consistent across waivers as well.
DHS-ODDS CO, CDDPs, Brokerages, and OHA staff collect QI information from the performance measures, of which the majority are consistent across all five waivers, related to the six assurances and other topic areas.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement System will ensure that all discovery and remediation activities have a process in place to ensure system improvement. The Oregon Health Authority and Oregon Department of Human Services will collaborate through inter-departmental meetings to coordinate these activities. These meetings will occur at least quarterly to report on the corrective actions and follow-up required to ensure system improvement.
ODHS and OHA staff re-evaluates the QIS at least once during each waiver renewal period (or more as deemed appropriate) and update the QIS strategies employed. From activities conducted by ODHS and OHA staff, QIS reports are created detailing discovery and remediation activities related to the six assurances and other parameters.
These staff and Waiver program representatives bring forth issues, trends, priorities and concerns related to the QIS on both individual and multi-waiver levels. These groups evaluate and make recommendations to amend the QIS, waivers, state plan, OARs and policies as necessary to promote high quality services for waiver
participants.
QIS reports are specific to each waiver. While the QIS is global and spans all waivers, separate reports are produced for each specific waiver operated by ODHS. Reports will cover the full range of waiver activities measured or assessed (level of care, qualified providers, service plans, participant health and welfare, financial accountability, administrative oversight) to develop recommendations for improvements in performance.
ODHS and OHA will provide these statewide reports documenting performance measures and remediation outcomes to the Medicaid Director, system's improvement committee and the MOCSC.
The OHA liaison and the MOCSC will review the reports to ensure follow-up and compliance with recommendations made not only by ODHS or CMS staff, the system's improvement committee, stakeholders and advocates, but also
those that may have been made by OHA and these entities previously. These reports are in addition to the periodic ongoing reports that are presented to OHA and the MOCSC at regularly scheduled meetings during each year.
ODHS staff compiles reviews and analyzes performance data through a variety of file reviews and data reports. Corrective action/remediation plans are required as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. ODHS, ODDS Central Office staff follow-up to ensure appropriate action is taken.
Additionally, OHA exercises oversight of Medicaid/CHIP programs by employing designated staff to partner with ODHS (OHA/ODHS liaison), participating in the system’s improvement committee, MOCSC, Steering Committee and other related
committees in reviewing and approving ODHS reports and documents. On a continuous and ongoing basis, OHA will review ODHS quality control processes for Medicaid/CHIP programs managed by ODHS to assure proper oversight of central office and field operations.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ◉ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

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).*

OHA contracts directly with ODHS, the Organized Health Care Delivery System (OHCDS) through the IAA. ODHS, as an Organized Health Care Delivery System, in accordance with 42 CFR 447.10(b), contracts with or enters into provider enrollment agreements, interagency agreements, grants or other similar arrangements with qualified individuals, entities or units of government to furnish Medicaid/CHIP administrative or programmatic services for which ODHS has responsibility. ODHS makes payment to providers of these services.
At provider enrollment or renewal, ODHS informs providers of their right to contract directly with OHA, the single state Medicaid agency.
OHA will establish direct provider agreements and make payment to any qualified provider who does not choose to contract with ODHS as the OHCDS.
ODHS reviews the qualifications of provider applicants and assures that waiver participants are free to choose qualified providers in their area. OHA includes oversight of provider qualification measures in their reviews of ODHS performance. This includes activities to assure that subcontract providers meet all applicable Medicaid requirements for services delivered.
For the Medically Fragile Waiver the State does not require independent financial statement audits because Waiver Case Management is provided by employees of ODHS and Environmental Safety Modifications, Family Training, Individual Directed Goods and Services, Special Diets, Specialized Medical Supplies and Vehicle Modifications are all provided by qualified vendors.

Secretary of State Oregon Audits Division
By statute, the Secretary of State, Oregon Audits Division (OAD) conducts audit work in compliance with Government Auditing Standards developed by the U.S. Government Accountability Office. Standards are developed by and for government auditors to ensure quality work is performed in the public interest. These audit standards contain requirements and guidance to assist auditors in objectively acquiring and evaluating sufficient, appropriate evidence as well as reporting the results.
A primary audit conducted by the OAD annually is the Statewide Single Audit. This audit includes an audit of the State of Oregon's financial statements and the state's internal controls and compliance with federal program requirements. Medicaid provider payments are reviewed as part of this audit. The review is based on federal guidelines, and includes client and provider eligibility to receive Medicaid funding.
The OAD also conducts performance audits of State agencies. These audits provide an objective and systematic examination of evidence to provide an independent assessment of a government organization, program, activity, or function. Like financial audits, the goal of these audits is to provide information to agency directors, the governor, the Legislature and citizens of Oregon to improve public accountability and facilitate decision-making by parties with responsibility for overseeing or initiating corrective action. The issues that performance audits cover vary, but generally address whether agencies are operating economically and efficiently, or whether they are achieving desired results.
In addition, the OAD also conducts information technology audits, including general control reviews, application control reviews, security reviews and system development reviews.
ODHS/OHA Internal Audit and Consulting
The Internal Audit and Consulting (IAC) unit serves both the Oregon Department of Human Services (ODHS) and the Oregon Health Authority (OHA) by identifying and evaluating risks, recommending changes to mitigate risks, and assessing the degree to which programs and processes conform to associated statutes, rules and policies. IAC follows "The International Standards for the Professional Practice of Internal Auditing" (Red Book, issued by the Institute of Internal Auditors).
IAC reports to all levels of agency and division management on the adequacy and effectiveness of the agencies' system of control and performance in carrying out assigned responsibilities so management can determine if:
• Risks are appropriately identified and managed.
• Programs, plans, and department objectives and goals are achieved.
• Significant financial, managerial and operating information is accurate, reliable, and timely.
• Employees' actions are in compliance with policies, standards, procedures, and applicable laws and regulations.
• Resources are acquired economically, used efficiently, and adequately protected.
IAC, in the performance of audits, is granted access to all necessary activities, records, property, and employees while upholding stringent accountability of safekeeping and confidentiality. The IAC auditors are in positions that have no direct authority over activities being reviewed, thus mitigating conflicts of interest.
The Chief Audit Officer of IAC reports functionally to both the ODHS Chief Operating Officer and the OHA Chief Financial Officer, and has necessary access to senior management of both ODHS and OHA.
ODHS/OHA Internal Audit and Consulting has additional responsibility to:
• Perform internal audits in accordance with applicable auditing standards.
• Make recommendations to management regarding opportunities for improvement as identified by the audits.
• Perform consulting services to assist management in meeting objectives, including but not limited to participation on project teams or advisory services as well as providing training.

• As necessary, assist in investigations of allegations of significant fraudulent activities within the agencies and notify management and the Audit Committee of the results.
The IAC unit facilitates the agencies' (ODHS and OHA) annual risk assessment process each year. This assessment is the basis for the annual internal audit work plan. To create each year's risk assessment summary, IAC leverages existing risk assessments from prior years and engages ODHS and OHA management and staff in additional discussions. The risks identified from prior periods are sent to responsible management for review and updates. Based on this review, and additional review by department management, a determination is made of which risks should be prioritized as top risks for audit consideration by the two agencies.
ODHS and OHA operate a joint committee, the Joint ODHS and OHA Audit Committee (Audit Committee). With the assistance of Internal Audit and Consulting Unit, the Audit Committee develops and approves an annual audit plan. The Audit Committee is comprised of executive management from both agencies and includes external partners.
The Audit Committee is a forum to address all internal and external audit issues affecting the two agencies, including the monitoring and disposition of those issues. The Audit Committee guides the functions and sets the priorities of the Internal Audit and Consulting unit within ODHS/OHA Shared Services. Committee guidance is compliant with ORS 184.360 and OAR 125-700-0010 through 125-700-0155 and in accordance with the Institute of Internal Auditor's International Standards for the Professional Practice of Internal Auditing.
Office of Payment Accuracy and Recovery

Office of Payment Accuracy and Recovery Audit staff from the Office of Payment Accuracy and Recovery (OPAR), Provider Audits Unit (PAU), a ODHS/OHA Shared Service, review payment records of Medicaid providers, by reviewing paid claims and ensuring they are supported by the progress/case note of service provided in accordance with the ISP which indicates the service to be provided. This is completed continually and ongoing, at a frequency of quarterly, based on a prioritized risk analysis and via a random sample method. The random sample is done using a stratified random sample method based on the Calvin Paper. Staff set audit priorities each year based upon assessed risk analysis. The estimate of overpayment is made utilizing a simple expansion with a standard error of the estimated overpayment and the confidence interval estimate of the total overpayment calculated from the data obtained from the sampled line items. The estimate of total overpayment is obtained by calculating the overpayment for each stratum and summing these overall strata.

A government body, an organization or an individual can trigger an audit. These auditors may conduct desk audits on on-site field audits as determined by the Auditor and PAU management. Auditors may consider other audits of the provider as described in OAR. Provider and Contractor Audits, Appeals and Post-Payment Recoveries are described in OAR 407-120-1505.
OPAR's Fraud Investigation Unit (FIU) and PAU receive reports of fraud in Medicaid programs and investigates allegations. FIU investigates allegations of consumer fraud. PAU investigates fraud 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.
PAU sends fraud referrals to the MFCU where there is a credible allegation of fraud. The MCFU reviews and investigates cases where there is a potential prosecution. In addition, PAU informally consults with the MFCU on other suspected cases of fraud.
OPAR maintains a hotline for anyone to report consumer fraud and provider fraud.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "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. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
PM29: Number and percent of waiver case management billable claims paid as specified in the approved waiver N: Number of claims appropriately coded and paid for in accordance with the reimbursement methodology. D: Total number of claims coded and paid for files reviewed.

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):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other***	

	Specify: *Biennially*	

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):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.*

Performance Measure:
PM28: Number and percent of claims approved with appropriate plan of care specified in the approved waiver. N: Number of claims approved in accordance with the appropriate plan of care D: Total number of claims approved for files reviewed

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):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence*

		Interval =
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *Biennially*	

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):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *Biennially*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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:
PM30: Number and percent of waiver claims approved using appropriate rate methodology specified in the approved waiver. N: Number of approved claims paid using the appropriate rate methodology. D: Total number of claims approved for files reviewed.

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):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *Biennially*	

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):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *Biennially.*

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.*

The frequency of data collection, aggregation and analysis is biennial with site and file reviews conducted on an ongoing basis with reviews at each site every two years. The sample universe will be comprised of waiver year 1 and 2 for the #40193, #40194 and #0565 waivers combined, to determine the statistically valid representative random sample size. The file review sample size used for all measures in Appendix D and two of the appendix G performance measures is based on a statistically valid representative random sample utilizing a 95% confidence level, 5% margin of error and 50% response distribution, as determined by the Raosoft sample size calculator found at http://www.raosoft.com/samplesize.html for the two-year cycle. This representative sample is proportioned across case management entities based on the percentage of the population served relative to the waiver population size. Half of the sample will be pulled for participants who were enrolled in waiver year one and the other half pulled for participants enrolled in waiver year two. Within the sample drawn each year of the biennial cycle, Oregon will over sample to account for multiple variable review, as well as to account for 'non-response' factors such as participants who are no longer enrolled in the waiver due to relocation out of state or death and participants whose length of enrollment within the review period is insufficient to produce results for the variables measured (e.g., service plan updated annually cannot be assessed for someone who is newly enrolled for less than 12 months).

All other performance measures utilize a 100% review process of the total population for the review period for the unit of analysis of the measure (e.g., waiver participants, providers, claims).

Oregon's sampling methodology is informed by the Sampling Guide included in Attachment D of the 1915c HCBS Waiver Technical Guide Resource Attachments. In particular, this sampling methodology comports with guidance regarding proportionate sampling described on page 24 and oversampling to account for the number of variables to be examined and non-response rate, both described on page 21.

The 0565, 40193 and 40194 waivers meet the following five CMS conditions:
1. Design of the waivers is the same or very similar;
2. This sameness or similarity is determined by comparing waivers on the approved waiver application appendices:
a. Participant Services,
b. Participant Safeguards, and
c. Quality Management;
3. The quality management approach is the same or very similar across waivers, including:
a. Methodology for discovering information (e.g., data systems, sample selection),
b. Manner in which individual issues are remedied,
c. Process for identifying and analyzing patterns/trends, and
d. Majority of the performance indicators are the same;
4. The provider network is the same or very similar; and
5. Provider oversight is the same or very similar."
Data and reports gathered and created by ODHS staff during quality reviews are reviewed and analyzed on a continuous and ongoing basis by designated OHA staff, including the OHA liaison to ODHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Upon completion of OHA' analysis and review of ODHS quality assurance data and reports, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document ODHS and OHA remediation efforts.
The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and ODHS. The MOCSC meets at least quarterly to coordinate and review all mutual policy issues related to the operation and administration of the Medicaid/CHIP program including state plan amendments, waiver requests, rules, procedures, and interpretive guidance. A Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) for OHA and ODHS meets at least twice per year to review Medicaid/CHIP-related policy. The Steering Committee is comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of policy-related issues and delineation of responsibilities, including establishment of a strategic plan for the two agencies.

ODHS staff address individual problems with designated OHA staff on an ongoing basis and during regularly scheduled meetings. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving ODHS reports, documents, rules, policies and guidelines. OHA, on a continuous and ongoing basis, reviews and provides input to ODHS quality control processes for Medicaid/CHIP programs managed by the ODHS to assure proper oversight of central office and field operations. This includes ongoing review and approval of ODHS operational oversight and quality assurance activities.
As designated OHA staff, the OHA liaison, and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Joint Policy and Operations Steering Committee outlined above, thus informing executive management of OHA and ODHS.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States 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.*

Individual remediation activities will require follow-up by the ODHS Quality Management Staff to determine that the corrective action was successfully completed by the field office, licensing or abuse investigation unit. The results of any remediation will be submitted to an inter-departmental workgroup for discussion, data collection and reporting. When individual and/or system-wide remediation activities are warranted based on discovery and analysis, the following time frames will be used to ensure these items are remediated in a timely manner. Because ODHS is monitoring the performance of its contractors (CMEs, and service providers)
Non-compliance will be determined by any performance measure that falls below 86% accuracy.
ODHS timelines for remediation:
Corrective Action Plans: Within 45 days of Department's identification of need for plan of correction, entities reviewed must submit a plan of correction.
Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 45 days of Department's approval of entity's plan of correction.
Completion of corrective actions: Within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff).
Timelines for systemic remediation:
Required system-wide changes: If changes require revision of administrative rules, the required changes will be completed within the time frames required by the administrative rule process, including Rule Advisory Committees (including stakeholder input), Administrative rule hearings and statutory filing time frames. If system-wide changes require waiver amendments, the process will be completed at the time of approval of the waiver amendment. This will include the 30 day public and 60 day tribal input period and 90 day approval process.
Follow-up to determine effectiveness of remediation activities will occur during the next discovery and review cycle using a comparison of compliance level pre- and post-remediation to determine the level of success with the remediation activity. After initial remediation is completed a follow-up will occur within 180 days to determine the effectiveness of the method. If additional remediation is required, it will be added to the corrective action plan.
The Quality Improvement System will ensure that all discovery and remediation activities have a process in place to ensure system improvement. The Oregon Health Authority and Oregon Department of Human Services will
collaborate through inter-departmental meetings to coordinate these activities. These meetings will occur at least quarterly to report on the corrective actions and follow-up required to ensure system improvement.
Remediation strategies include training, revision of administrative processes and procedures, administrative rule revisions and waiver amendments. These strategies will be used based on the results of the discovery and analysis of the related performance measure. If compliance with the performance measure falls below 86%, a request for a corrective action plan, including activities and time lines for completion and follow-up will be required. Follow-up will include a discovery process using a valid random sample. Follow up discovery will be conducted using the standardized survey instruments and methods utilized during the initial discovery phase.

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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *ODHS-Site/file reviews conducted ongoing with on-site reviews every two years OHA-reviews ODHS through regularly scheduled MOCSC meetings to identify trends that may require statewide QIS changes*

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 guidelines for all waiver services are established and published by the Department. Costs of services are estimated based upon ODHS published allowable rates and other limitations imposed by Oregon Administrative Rule.
Consistent with the roles and responsibilities identified in the ODHS/OHA Interagency Agreement, ODHS (the operating agency) commences the public notice and comment period adhering with the requirements of 42 CFR 447.205 and the approved Medicaid State Plan. Designated staff from the OHA (the Medicaid Agency) reviews and approves the public notice materials prior to ODHS releasing the notice and monitors throughout the process to assure that all requirements and timeframes are met. Once the public notice and comment period has expired, OHA staff reviews the comments and ODHS responses to comments and provides input, if necessary.

Waiver Case Management for contracted case management entities:
Oregon will pay for qualifying waiver case management (WCM) activities on a per-contact-per-day methodology. Oregon will limit payment to one waiver case management contact per individual per day. If two distinct, qualifying waiver case management contacts are provided to a single individual in a single day, Oregon will only pay for one waiver case management contact for that individual. Conducting functional needs assessment is excluded from this limitation.
The agency's state-wide rates were set as of 07/01/2009 and are effective for services on or after that date. All rates are published on the agency's website. The fee schedule and any annual/periodic adjustments to the fee schedule are published on the department's website at http://www.dhs.state.or.us/spd/tools/dd/cm/ODDS-Expenditure-Guidelines.pdf.

The waiver case management rate is derived using the following formula:
Total cost to ODHS, ODDS to provide waiver case management divided by projected biennial case management contacts.
The total cost to ODHS of providing waiver case management includes:
• Waiver case management staff salary and other personnel expenses;
• Supervisory salary and other personnel expenses in support of WCM services; and
• Indirect expenses (General government service charges, worker's comp, property insurance, etc).
The sum of these expenses is then multiplied by a percentage determined by the Legislature.
ODDS will monitor waiver case management utilization to ensure services are being administered economically and efficiently. Adjustments to the waiver case management rate may be made periodically during the biennium if waiver case management contacts are materially different from beginning-of-biennium projections.
New waiver case management contact rates will be established at the beginning of each state biennium period using this same methodology.

Waiver case management for employees of ODHS, Office of Developmental Disabilities Services (ODDS)-
The rate setting methodology incorporates wages and benefits as well as other payroll expenditures (OPE), allowable administration percentages, and other costs associated with operating a business. It also incorporates information on revenue and expenses about the service so that ODHS can assure that the total funding does not exceed the cost of providing the case management service.

All rate information for employment services can be found in Main B-Optional section.
Family Training – Conferences and Workshops:
Conference - the actual cost of enrollment fees and educational materials.

Individual Directed Goods and Services, Environmental Safety Modifications, Specialized Medical Equipment, and Vehicle Modifications are the actual, most cost-effective price for the product offered through appropriate vendors. In order to determine the most cost-effective price a competitive bidding process may be used for Environmental Safety Modifications and Vehicle Modifications.

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 ODHS, an OHCDS, directly.
Provider billings for Waiver services flow directly to the ODHS Express Payment and Reporting System (eXPRS) and are paid through the State Financial Management Application or SFMA once the billing claim has been validated. The eXPRS payment system is an electronic, web-based system that manages all aspects of client enrollment, rate authorization, provider claims and billing, and subsequent reports related to those functions for these services paid through eXPRS. Payment for validated claims is made directly back to the provider of service.

Appendix I: Financial Accountability

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

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:*

Providers bill for services listed on the plan of care. Services are only paid if the child was actively enrolled on the waiver for the period billed. The CME confirms with families by phone, e-mail, or documentation review that services billed were delivered.
For Waiver services the eXPRS payment system interfaces with the MMIS recipient subsystem and updates a client's Medicaid and service eligibility daily. The service provider enters the claim into eXPRS, the MMIS recipient subsystem is checked to verify the individual's Medicaid and waiver eligibility. If eligibility is confirmed, payment is made. If an individual is not eligible for a Waiver service for the date(s) of service, the payment claim is suspended. There is no possibility of payment duplications within the eXPRS system.
If an individual is not eligible for a Waiver service on the date(s) of service, payment can be made using State General Fund dollars only.
Waiver Case Management must also have an accepted (active) client prior authorization (CPA) in eXPRS prior to payment. For services authorized and paid via eXPRS, the case manager must create and submit the CPAs in eXPRS which authorizes the expenditure of Department funds. For these waiver services paid through eXPRS, the CPA establish permission to expend funds for client services and establish a limit on ODHS payments. After a service has been delivered, the Provider submits a payment claim via eXPRS. The system checks the claim against the prior authorizations, client eligibility, and if the claim complies with all authorizations, payment is made to the provider.
Waiver Case Management payments are made post delivery of service via the eXPRS payment system. Providers can only submit claims for payment after the service is delivered (the system will not allow any prospective claims). The authorization of client services in eXPRS is managed by the CME.
Prior authorization and payment for family training conferences and workshops are paid prospectively for family members attending conferences. Payment is made directly to the conference/workshop presenter.

If when audited there are findings that necessitate a recoupment, the state will have the provider void the claims in the system. The state will document the reason and the system will create a liability for this provider. The liability will be recovered with the appropriate match rates. If no future billings are expected, the state will calculate the FFP of the voided claims, repay the federal match and turn over the liability as all General Fund to the Office of Payment and Recovery to recoup.

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:

Waiver services are paid directly by the Department (operating agency) to the authorized provider using the Express Payment and Reporting System (eXPRS).
Waiver Case Management: service authorization enrollments and payments will be managed for these services via eXPRS. The CME is required to maintain required documentation external to eXPRS to support the authorization
of the service, client service need and preference, and the applicable rate setting methodology or tool. Service delivery providers are required to maintain external to eXPRS documentation of service delivery to support claims submitted and payment received for services rendered.
ODHS pays all providers directly. No Medicaid payment goes to or is made by 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:

OHA contracts directly with ODHS, the Organized Health Care Delivery System (OHCDS) through the IAA.
ODHS, as an Organized Health Care Delivery System, in accordance with 42 CFR 447.10(b), contracts with or enters into provider enrollment agreements, interagency agreements, grants or other similar arrangements with qualified individuals, entities or units of government to furnish Medicaid/CHIP administrative or programmatic services for which ODHS has responsibility. ODHS makes payment to providers of these services.
At provider enrollment or renewal, ODHS informs providers of their right to contract directly with OHA, the single state Medicaid agency.
OHA will establish direct provider agreements and make payment to any qualified provider who does not choose to contract with ODHS as the OHCDS.
ODHS reviews the qualifications of provider applicants and assures that waiver participants are free to choose qualified providers in their area. OHA includes oversight of provider qualification measures in their reviews of ODHS performance. This includes activities to assure that subcontract providers meet all applicable Medicaid requirements for services delivered.
ODHS 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 ODHS to review these records for audit purposes. Providers are required to meet the requirements stated in OAR 411.351.0000 et seq.

☐ ***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:

Case managers employed by ODHS, ODDS, Children's Intensive In-Home Services and Community Developmental Disabilities Programs provide waiver case management services.

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:

- ◉ ***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:

OHA contracts directly with ODHS, the Organized Health Care Delivery System (OHCDS) through the IAA. ODHS, as an Organized Health Care Delivery System, in accordance with 42 CFR 447.10(b), contracts with or enters into provider enrollment agreements, interagency agreements, grants or other similar arrangements with qualified individuals, entities or units of government to furnish Medicaid/CHIP administrative or programmatic services for which ODHS has responsibility. ODHS makes payment to providers of these services.
At provider enrollment or renewal, ODHS informs providers of their right to contract directly with OHA, the single state Medicaid agency.
OHA will establish direct provider agreements and make payment to any qualified provider who does not choose to contract with ODHS as the OHCDS.
ODHS reviews the qualifications of provider applicants and assures that waiver participants are free to choose qualified providers in their area. OHA includes oversight of provider qualification measures in their reviews of ODHS performance. This includes activities to assure that subcontract providers meet all applicable Medicaid requirements for services delivered.
ODHS 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 ODHS 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 Oregon Department of Human Services and the Secretary of States 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.

ODHS auditors periodically evaluate provider financial condition and contractual compliance, review fiscal audits performed on contractors by other agencies, provide consultation to the Secretary of States Division of Audits programs, and evaluate provider financial system issues for compliance with federal and state standards. ODHS determines the frequency of audits and also requests random records monthly. Case managers review all provider payments monthly. ODHS and state auditors audit ODDS 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. ODHS auditors perform both desk reviews and on-site examinations of providers records, facilities and operations, and other information Internal Programs. ODHS auditors provide timely, accurate, independent and objective information about ODHS operations and programs. An internal audit committee made up of representatives from each ODHS administrative unit 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 CPAs (AICPA), the Federal General Accounting Office (GAO) Yellow Book, Institute of Internal Auditors (IIA), and Information Systems Audit and Control Association (ISACA). ODHS 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 ODHS administration regarding issues such as: economical and efficient use of resources; progress meeting ODHS goals and outcomes; reliability and integrity of information; consumer health and safety; compliance with laws, regulations, policies, procedures, and contact 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

States 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 states 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 auditors work papers for compliance with the standards. In addition to audit activities of the ODHS Audit Unit and Secretary of State Audit Division.
The ODHS Office of Payment Accuracy and Recovery receives reports of fraud in ODHS programs and investigates allegations. The Office maintains a hotline for anyone to report fraud and will investigate allegations against providers for allegations of billing for services not rendered, intentionally billing in duplicate, billing for higher level of services than were delivered, billing for services provided by unlicensed or otherwise ineligible practitioners, and kickback schemes.

iii. Contracts with MCOs, PIHPs or PAHPs.

- (◉) ***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.***
- ( ) ***This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver 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.

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:
Do not complete this item.

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-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital

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	6431.68	172099.60	178531.28	245617.71	78075.42	323693.13	145161.85
2	6431.68	175541.59	181973.27	250530.06	79636.93	330166.99	148193.72
3	6431.68	179052.43	185484.11	255540.66	81229.67	336770.33	151286.22
4	6431.68	182633.47	189065.15	260651.47	82854.26	343505.73	154440.58
5	6431.68	186286.14	192717.82	265864.50	84511.35	350375.85	157658.03

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 Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Hospital
Year 1	123	123
Year 2	123	123
Year 3	123	123
Year 4	123	123
Year 5	123	123

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.*

322 Days -

Actual LOS from most recent 372 waiver report (WY2).

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 and methodology for these estimates is as follows:*

Factor D estimates were based on actual expenditures for services delivered in FY 2021. Units-per-user and cost-per-unit estimates were an average calculated from actual expenditures from FY21, FY22 and FY23.
Reliable statistics cannot be applied due to actual utilization of these services and actual number of users being unpredictable from year to year, therefore the state has calculated these numbers to remain stagnant. The state does not apply inflation to the cost-per-unit estimates for this waiver. If the cost-per-unit has more than a 10% variance in any waiver year, the waiver will be amended.

For Employment Path Services, Job Coaching - Initial, Job Coaching - Ongoing and Supported Employment - Small Group Employment Support are based from adult utilization of the same services in the #0375 waiver but with lower assumptions due to individuals still being in school. Maintenance Job Coaching is not available until the individual has been working for 24 months, so it is assumed individuals in this waiver will likely have transitioned out of this waiver prior to this service being utilized.
Projections are low due to IDEA being responsible to provide for some of these services. However, Oregon is an Employment First state and wants these services to be available. It is anticipated that once these services have been available to individuals in this waiver, there will be a clearer methodology for future usage. Due to the significant needs of individuals in this waiver the average cost per unit is based on category 3 of the employment rate models.

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:*

Factor D' is derived from actual expenditures reported on most recent 372 report (WY2) and then included actual 1915 K expenditures from same review period (FY21). The expenditures are post Part D Medicare implementation and reflect the removal of prescribed drugs. ODHS has applied a 2% inflationary increase for mandated program service expenditures as outlined in Department of Administrative Services' 2021-23 Budget and Legislative Concept Instruction document.

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:*

ODHS based Factor G cost projections on actual expenditures incurred for delivery of hospital services to similar children for FY22 and projected forward.
ODHS has applied a 2% inflationary increase for mandated program service expenditures as outlined in Department of Administrative Services' 2021-23 Budget and Legislative Concept Instruction document.

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:*

ODHS based Factor G' cost projections on actual expenditures incurred for delivery of acute care services to similar children served in hospitals for CY22 and projected forward.
ODHS has applied a 2% inflationary increase for mandated program service expenditures as outlined in Department of Administrative Services' 2021-23 Budget and Legislative Concept Instruction document.

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	
Employment Path Services	
Supported Employment - Individual Employment Support	
Waiver Case Management	
Discovery/Career Exploration Services	
Environmental Safety Modifications	

Waiver Services	
Family Training	
Individual Directed Goods and Services	
Specialized Medical Supplies	
Supported Employment - Small Group Employment Support	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Path Services Total:							6090.40
Employment Path Services	☐	hour	1	230.00	26.48	6090.40	
Supported Employment - Individual Employment Support Total:							28206.72
Job Development - Retention	☐	outcome	1	1.00	1663.97	1663.97	
Job Development - Placement	☐	outcome	1	1.00	2198.45	2198.45	
Job Coaching - Ongoing	☐	hour	1	220.00	71.65	15763.00	
Job Coaching - Initial	☐	hour	1	205.00	41.86	8581.30	
Job Coaching - Maintenance	☐	hour	0	0.00	44.74	0.00	
Waiver Case Management Total:							608407.20
Waiver Case Management	☐	Encounter	123	12.00	412.20	608407.20	
Discovery/Career Exploration Services Total:							2250.22
Discovery/Career	☐					2250.22	

GRAND TOTAL:	791096.68
Total: Services included in capitation:	
Total: Services not included in capitation:	791096.68
Total Estimated Unduplicated Participants:	123
Factor D (Divide total by number of participants):	6431.68
Services included in capitation:	
Services not included in capitation:	6431.68
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Exploration Services		outcome	1	1.00	2250.22		
Environmental Safety Modifications Total:							**199.94**
Environmental Safety Modifications	☐	Modification	1	1.00	199.94	**199.94**	
Family Training Total:							**120.00**
Education	☐	Events	1	1.00	120.00	**120.00**	
Individual Directed Goods and Services Total:							**553.35**
Individual Directed Goods and Services	☐	Purchase	1	1.00	553.35	**553.35**	
Specialized Medical Supplies Total:							**84084.72**
Specialized Medical Supplies	☐	Purchase	102	4.00	206.09	**84084.72**	
Supported Employment - Small Group Employment Support Total:							**810.60**
Supported Employment - Small Group Employment Support	☐	hour	1	30.00	27.02	**810.60**	
Vehicle Modifications Total:							**60373.53**
Vehicle Modifications	☐	Modification	3	1.00	20124.51	**60373.53**	

GRAND TOTAL:	**791096.68**
Total: Services included in capitation:	
Total: Services not included in capitation:	791096.68
Total Estimated Unduplicated Participants:	**123**
Factor D (Divide total by number of participants):	**6431.68**
Services included in capitation:	
Services not included in capitation:	6431.68
Average Length of Stay on the Waiver:	322

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Path Services Total:							**6090.40**
Employment Path Services	☐	hour	1	230.00	26.48	**6090.40**	
Supported Employment - Individual Employment Support Total:							**28206.72**
Job Development - Retention	☐	outcome	1	1.00	1663.97	**1663.97**	
Job Development - Placement	☐	outcome	1	1.00	2198.45	**2198.45**	
Job Coaching - Ongoing	☐	hour	1	220.00	71.65	**15763.00**	
Job Coaching - Initial	☐	hour	1	205.00	41.86	**8581.30**	
Job Coaching - Maintenance	☐	hour	0	0.00	44.74	**0.00**	
Waiver Case Management Total:							**608407.20**
Waiver Case Management	☐	Encounter	123	12.00	412.20	**608407.20**	
Discovery/Career Exploration Services Total:							**2250.22**
Discovery/Career Exploration Services	☐	outcome	1	1.00	2250.22	**2250.22**	
Environmental Safety Modifications Total:							**199.94**
Environmental Safety Modifications	☐	Modification	1	1.00	199.94	**199.94**	
Family Training Total:							**120.00**
Education	☐	Event	1	1.00	120.00	**120.00**	
Individual Directed Goods and Services Total:							**553.35**
Individual Directed Goods and Services	☐	Purchase	1	1.00	553.35	**553.35**	
Specialized Medical Supplies Total:							**84084.72**
Specialized Medical Supplies	☐	Purchase	102	4.00	206.09	**84084.72**	
Supported							**810.60**

GRAND TOTAL:	**791096.68**
Total: Services included in capitation:	
Total: Services not included in capitation:	791096.68
Total Estimated Unduplicated Participants:	**123**
Factor D (Divide total by number of participants):	**6431.68**
Services included in capitation:	
Services not included in capitation:	6431.68
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment - Small Group Employment Support Total:							
Supported Employment - Small Group Employment Support	☐	hour	1	30.00	27.02	**810.60**	
Vehicle Modifications Total:							**60373.53**
Vehicle Modifications	☐	Modification	3	1.00	20124.51	**60373.53**	

GRAND TOTAL:	**791096.68**
Total: Services included in capitation:	
Total: Services not included in capitation:	791096.68
Total Estimated Unduplicated Participants:	**123**
Factor D (Divide total by number of participants):	**6431.68**
Services included in capitation:	
Services not included in capitation:	6431.68
Average Length of Stay on the Waiver:	322

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Path Services Total:							**6090.40**
Employment Path Services	☐	hour	1	230.00	26.48	**6090.40**	
Supported Employment - Individual Employment Support Total:							**28206.72**
Job Development - Retention	☐	outcome	1	1.00	1663.97	**1663.97**	
Job Development - Placement	☐	outcome	1	1.00	2198.45	**2198.45**	

GRAND TOTAL:	**791096.68**
Total: Services included in capitation:	
Total: Services not included in capitation:	791096.68
Total Estimated Unduplicated Participants:	**123**
Factor D (Divide total by number of participants):	**6431.68**
Services included in capitation:	
Services not included in capitation:	6431.68
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Job Coaching - Ongoing	☐	hour	1	220.00	71.65	15763.00	
Job Coaching - Initial	☐	hour	1	205.00	41.86	8581.30	
Job Coaching - Maintenance	☐	hour	0	0.00	44.74	0.00	
Waiver Case Management Total:							608407.20
Waiver Case Management	☐	Encounter	123	12.00	412.20	608407.20	
Discovery/Career Exploration Services Total:							2250.22
Discovery/Career Exploration Services	☐	outcome	1	1.00	2250.22	2250.22	
Environmental Safety Modifications Total:							199.94
Environmental Safety Modifications	☐	Modification	1	1.00	199.94	199.94	
Family Training Total:							120.00
Education	☐	Event	1	1.00	120.00	120.00	
Individual Directed Goods and Services Total:							553.35
Individual Directed Goods and Services	☐	Purchase	1	1.00	553.35	553.35	
Specialized Medical Supplies Total:							84084.72
Specialized Medical Supplies	☐	Purchase	102	4.00	206.09	84084.72	
Supported Employment - Small Group Employment Support Total:							810.60
Supported Employment - Small Group Employment Support	☐	hour	1	30.00	27.02	810.60	
Vehicle Modifications Total:							60373.53
Vehicle Modifications	☐	Modification	3	1.00	20124.51	60373.53	

GRAND TOTAL:	791096.68
Total: Services included in capitation:	
Total: Services not included in capitation:	791096.68
Total Estimated Unduplicated Participants:	123
Factor D (Divide total by number of participants):	6431.68
Services included in capitation:	
Services not included in capitation:	6431.68
Average Length of Stay on the Waiver:	322

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Path Services Total:							6090.40
Employment Path Services	☐	hour	1	230.00	26.48	6090.40	
Supported Employment - Individual Employment Support Total:							28206.72
Job Development - Retention	☐	outcome	1	1.00	1663.97	1663.97	
Job Development - Placement	☐	outcome	1	1.00	2198.45	2198.45	
Job Coaching - Ongoing	☐	hour	1	220.00	71.65	15763.00	
Job Coaching - Initial	☐	hour	1	205.00	41.86	8581.30	
Job Coaching - Maintenance	☐	hour	0	0.00	44.74	0.00	
Waiver Case Management Total:							608407.20
Waiver Case Management	☐	Encounter	123	12.00	412.20	608407.20	
Discovery/Career Exploration Services Total:							2250.22
Discovery/Career Exploration Services	☐	outcome	1	1.00	2250.22	2250.22	
Environmental Safety Modifications Total:							199.94
Environmental Safety Modifications	☐	Modification	1	1.00	199.94	199.94	
Family Training Total:							120.00

GRAND TOTAL:	791096.68
Total: Services included in capitation:	
Total: Services not included in capitation:	791096.68
Total Estimated Unduplicated Participants:	123
Factor D (Divide total by number of participants):	6431.68
Services included in capitation:	
Services not included in capitation:	6431.68
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Education	☐	Event	1	1.00	120.00	120.00	
Individual Directed Goods and Services Total:							553.35
Individual Directed Goods and Services	☐	Purchase	1	1.00	553.35	553.35	
Specialized Medical Supplies Total:							84084.72
Specialized Medical Supplies	☐	Purchase	102	4.00	206.09	84084.72	
Supported Employment - Small Group Employment Support Total:							810.60
Supported Employment - Small Group Employment Support	☐	hour	1	30.00	27.02	810.60	
Vehicle Modifications Total:							60373.53
Vehicle Modifications	☐	Modification	3	1.00	20124.51	60373.53	

GRAND TOTAL:	791096.68
Total: Services included in capitation:	
Total: Services not included in capitation:	791096.68
Total Estimated Unduplicated Participants:	123
Factor D (Divide total by number of participants):	6431.68
Services included in capitation:	
Services not included in capitation:	6431.68
Average Length of Stay on the Waiver:	322

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Path							6090.40

GRAND TOTAL:	791096.68
Total: Services included in capitation:	
Total: Services not included in capitation:	791096.68
Total Estimated Unduplicated Participants:	123
Factor D (Divide total by number of participants):	6431.68
Services included in capitation:	
Services not included in capitation:	6431.68
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:							
Employment Path Services	☐	hour	1	230.00	26.48	**6090.40**	
Supported Employment - Individual Employment Support Total:							**28206.72**
Job Development - Retention	☐	outcome	1	1.00	1663.97	**1663.97**	
Job Development - Placement	☐	outcome	1	1.00	2198.45	**2198.45**	
Job Coaching - Ongoing	☐	hour	1	220.00	71.65	**15763.00**	
Job Coaching - Initial	☐	hour	1	205.00	41.86	**8581.30**	
Job Coaching - Maintenance	☐	hour	0	0.00	44.74	**0.00**	
Waiver Case Management Total:							**608407.20**
Waiver Case Management	☐	Encounter	123	12.00	412.20	**608407.20**	
Discovery/Career Exploration Services Total:							**2250.22**
Discovery/Career Exploration Services	☐	outcome	1	1.00	2250.22	**2250.22**	
Environmental Safety Modifications Total:							**199.94**
Environmental Safety Modifications	☐	Modification	1	1.00	199.94	**199.94**	
Family Training Total:							**120.00**
Education	☐	Events	1	1.00	120.00	**120.00**	
Individual Directed Goods and Services Total:							**553.35**
Individual Directed Goods and Services	☐	Purchase	1	1.00	553.35	**553.35**	
Specialized Medical Supplies Total:							**84084.72**
Specialized Medical Supplies	☐	Purchase	102	4.00	206.09	**84084.72**	
Supported Employment - Small							**810.60**

GRAND TOTAL:	**791096.68**
Total: Services included in capitation:	
Total: Services not included in capitation:	791096.68
Total Estimated Unduplicated Participants:	**123**
Factor D (Divide total by number of participants):	**6431.68**
Services included in capitation:	
Services not included in capitation:	6431.68
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Employment Support Total:							
Supported Employment - Small Group Employment Support	☐	hour	1	30.00	27.02	**810.60**	
Vehicle Modifications Total:							**60373.53**
Vehicle Modifications	☐	Modification	3	1.00	20124.51	**60373.53**	

GRAND TOTAL:	**791096.68**
Total: Services included in capitation:	
Total: Services not included in capitation:	791096.68
Total Estimated Unduplicated Participants:	**123**
Factor D (Divide total by number of participants):	**6431.68**
Services included in capitation:	
Services not included in capitation:	6431.68
Average Length of Stay on the Waiver:	322