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Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

i. Eligibility

Community First Choice Option services are available to State plan eligible groups as described in Section 2.2-A of the State plan. These individuals are eligible for medical assistance under the State plan and are in an eligibility group that includes Nursing Facility services or are below 150% of federal poverty level if they are in an eligibility group that doesn't include Nursing Facility services.

The State, through the person-centered plan coordinator or state trained assessor will determine initially, and at least annually, that individuals require the level of care provided in a hospital, a nursing facility, an intermediate care facility for Individuals with Intellectual Disabilities (ICF/ID), an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over. Level of Care (LOC) for individuals under age 21 and 65 and over needing psychiatric services is determined using hospital level of care criteria. Different tools are utilized in order to accurately assess an individual's specific needs based on the institutional Level of Care being assessed.

The "Client Assessment and Planning System (CAPS)" is the tool used to establish nursing facility level of care. It is a single entry data system used for completing a comprehensive and holistic assessment, surveying the individual's physical, mental, and social functioning, and identifying risk factors, individual choices, and preferences, and the status of service needs. The tool allows for identification of needs being met utilizing natural supports, state plan and waivered services, thus allowing for a full and comprehensive assessment and service plan. The CAPS documents the level of need and calculates the individual's service priority level (in accordance with OAR chapter 411, division 015), calculates the service payment rates, and accommodates individual participation in service planning. Individuals are actively involved in the assessment process and will have the opportunity to identify goals, strengths and needs. They will be allowed to have anyone they would like to participate in the assessment process.

A standardized level of care assessment tool is used to determine whether an individual meets the institutional criteria for ICF/IDD. The LOC assessment ensures that the impairments indicated are explicitly related to eligibility and meets the criteria for a significant impairment.

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The tool uses information regarding the individual's qualifying diagnosis, and may include IQ and adaptive impairment scores based on an assessment of functional areas to make the determination.

Once approved, the person-centered plan coordinator must review the individual's service needs at least annually and more frequently if the individual's functional needs change or if requested by the individual. The date of review is required, indicating that the review has been completed and the individual continues to meet the Level of Care criteria. A case note of this will also be made to the individual's case management file.

All individuals considered for the Hospital Level of Care are assessed using the Level of Care assessment form and MFCU clinical criteria. The MFCU Clinical Criteria combined with the Level of Care Assessment Form are the complete level of care evaluation. The Clinical Criteria tool assesses and scores various care elements that the assessor expects to last six months or more. It measures nursing and other intervention needs, factoring in frequency and intensity of the care needed in the following: Skin/Physical Management; Metabolic: GI/Feeding; Neurological; Urinary/Kidney; Respiratory; and Vascular. Individuals must have a physician's signature that hospital level of care is required.

Individuals who are receiving medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must continue to meet all 1915(c) requirements and must receive at least one home and community-based waivered service per month. Individuals receiving services through CFC will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State plan, waiver, grant or demonstration but will not be allowed to receive duplicative services in CFC or any other available community-based services.

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For Individuals eligible under section 1902(a) (10)(A)(ii)(VI) of the Act who continue to meet all of the 1915(c) waiver requirements and who are receiving at least one 1915(c) waiver service a month, excess income determined under 42 C.F.R. 435.726 is applied, in addition to the cost of 1915(c) waiver services, to the cost of 1915(k) services. Therefore, excess income is applied to both 1915(c) waiver and 1915(k) services.

The LOC assessment is just one step in the planning process. Another step is the functional needs assessment that identifies the needs of the individual that must be addressed to ensure their safety and well-being and to ensure that individuals do not become unnecessarily institutionalized. The person-centered service plan (PCSP) that is individualized to address the individual's strengths, supports, goals and ensures their independence, dignity and well-being, is also completed.

ii. Service Delivery Models

_X_ Agency Model - The Agency Model is based on the person-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by entities under a contract.

_____ Self-Directed Model with service budget – This Model is one in which the individual has both a service plan and service budget based on the person-centered assessment of need.

____ Direct Cash
____ Vouchers
____ Financial Management Services in accordance with 441.545(b) (1).
____ Other Service Delivery Model as described below:

iii. Service Package

A. The following are included CFC services (including service limitations):

Attendant services and supports assist in accomplishing activities of daily living, instrumental activities of daily living and health related tasks through hands-on assistance, supervision, or cueing.

Services may be provided in the individual's home through enrolled homecare workers, personal support workers, in-home agencies or in a licensed, certified or endorsed community programs/settings of their choice.

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Programs/settings meet the home and community-based criteria in 441.530. The service providers are all existing provider types in Oregon's service delivery system.

1. Assistance with ADLs, IADLs and health-related tasks through hands-on assistance, supervision, and/or cueing.

The State will cover services and supports related to core activities of daily living including: assistance with bathing/personal hygiene, dressing, eating, mobility (ambulation, transferring and positioning), bowel care and bladder care, stand-by support, cognition, memory care and behavior supports.

Hands-on assistance, supervision, and/or cueing is defined as:

- "Cueing and/or reassurance" means giving verbal or visual clues and encouragement during the activity to help the individual complete activities without hands-on assistance.
- "Hands-on" means a provider physically performs all or part of an activity because the individual is unable to do so.
- "Monitoring" means a provider must observe the individual to determine if intervention is needed.
- "Redirection" means to divert the individual to another more appropriate activity.
- "Set-up" means getting personal effects, supplies, or equipment ready so that an individual can perform an activity.
- "Stand-by" means a provider must be at the side of an individual ready to step in and take over the task should the individual be unable to complete the task independently.
- "Support" means to enhance the environment to enable the individual to be as independent as possible.
- "Memory care support" includes services related to observing behaviors, supervision, and intervening as appropriate in order to safeguard the service recipient against injury, hazard or accident. These specific supports are designed to support individuals with cognitive impairments.

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The State will cover IADL supports including light housekeeping, laundry, medication management, meal preparation, shopping, and chore services.

- Chore Services are not housekeeping and are not included in the "Service supports" listed above. These services are intended to ensure that the individual's home is safe and allows for independent living. Specific services include heavy cleaning to remove hazardous debris or dirt in the home and yard hazard abatement to ensure the outside of the home is safe for the individual to traverse and enter and exit the home.

ADL and IADL supports will be provided by enrolled homecare workers, personal support workers, in-home agencies or in a licensed, certified or endorsed community setting of the individual's choice.

The state will provide Long-term Care Community Nursing Services (LTCCNS) to support health related tasks within the state's nurse practice act. These services include nurse delegation and care coordination for eligible individuals. This service does not include direct nursing care and the services are not covered by other Medicaid spending authorities.

"Delegation means that a Registered Nurse authorizes an unlicensed person to perform a task of a nursing care in selected situations and indicates that authorization in writing. The delegation process includes nursing assessment of a client in a specific situation, evaluation of the ability of the unlicensed persons, teaching the task, ensuring supervision of the unlicensed person and re-evaluating the task at regular intervals." These services are designed to assist the individual and care provider in maximizing the individual's health status and ability to function at the highest possible level of independence in the least restrictive setting.

Services include:

- Evaluation and identification of supports that minimize health risks, while promoting the individual's autonomy and self-management of healthcare;
- Medication reviews;
- Collateral contact to the person-centered plan coordinator regarding the individual's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered service plan; and
- Delegation of nursing tasks, within the requirement of Oregon's nurse practice act, to an individual's caregivers so that caregivers can safely perform health related tasks.

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The following list identifies criteria that may lead to a referral for LTCCNS.

- Need for the eligible individual, family member or care provider education;
- Need for delegation of a nursing care task;
- Medication safety issues or concerns;
- Unexpected increased use of emergency care, physician visits or hospitalizations;
- Changes in behavior or cognition;
- Nutrition, weight, or dehydration issues;
- Pain Issues;
- History of recent, frequent falls;
- Potential for skin breakdown or recently resolved skin breakdown; and
- Eligible individual who does not follow medical advice.

Long-term Care Community Nurses also assist in providing safe and appropriate community care supports and managing chronic diseases. Services are specific addressing health related tasks and do not duplicate services provided through other state plan or waiver authorities. LTCCNS provide person-centered plan coordinators, care providers and health professionals with information that they need to maintain the individual's health, safety, and community living situation while honoring their autonomy and choices {OAR 411-048-0150 (2)(a).

The LTCCN services may be delivered by the following enrolled Medicaid providers:

- An licensed Registered Nurse (RN) who is a self-employed provider;
- Licensed Home Health agencies; or
- Licensed In-Home agencies.

2. Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks.

Services include functional skills trainings, coaching, and prompting the individual to accomplish the ADL, IADL and health-related skills. Services will be specifically tied to the functional needs assessment and person-centered service plan and are a means to increase independence, preserve functioning, and reduce dependency of the service recipient.

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A worker may provide training and maintenance activities under the following conditions:

- The need for skill training or maintenance activities has been determined through the assessment process and has been authorized as part of the individual service plan;
- The activities are for the sole benefit of the individual and are only provided to the individual receiving CFC services;
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the person has a progressive medical condition;
- The activities are provided consistent with the stated preferences and outcomes in the individual support plan;
- The activities are provided concurrent with the performance of ADL, IADL, and health related tasks as described in the earlier section;
- Training and skill maintenance activities that involve the management of behavior during the training of skills, must use positive reinforcement techniques; and
- The provider must receive training about appropriate techniques for skill training and maintenance activities.

Skill training and maintenance activities do not include therapy or nursing services that must be performed by a licensed therapist or nurse, and are otherwise covered under the state plan, but may be used to complement therapy or nursing goals when authorized and coordinated through the person-centered service plan.

The majority of these services will be provided by state authorized skills trainers or programs who have demonstrated expertise in assisting individuals in the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living and instrumental activities of daily living.

Long-term Care Community Nursing Services are also in this category of services. LTCCNS nurses, within the scope of the state's nurse practice act requirements, assist individuals in the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish health related tasks. Community nurses are licensed registered nurses with the expertise to provide these skills.

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3. Back-up systems or mechanisms to ensure continuity of services and supports.

The state will cover back-up systems and mechanisms to ensure the continuity of services and supports and the safety and well-being of the individual. These systems and mechanisms include:

- Electronic back-up systems:
    - Emergency Response Systems provide back-up for individuals who live alone or are alone for significant periods of time in their own homes.
    - Electronic devices to secure help in emergency for safety in the community and other reminders that will help an individual with activities such as medication management, eating or other monitoring activities.
        - Examples of electronic devices include Personal Emergency Response Systems, medication minders, and alert systems (for meal preparation, ADL and IADL supports that increase an individual's independence). Mobile electronic devices and other assistive technology will be reviewed on a case-by-case basis to determine cost-effectiveness and the ability to replace human interventions as identified in the person-centered service plan. Reviews will be conducted by the person-centered plan coordinator. Expenditures over $1200 per year must receive prior approval from the DHS policy office.
    - Assistive Technology provides additional security to individuals and replaces the need for direct interventions. Assistive Technology also allows the individual to self-direct their care and maximizes independence.
        - Examples of assistive technology include, but are not limited to, motion and sound sensors, two-way communication systems, automatic faucet and soap dispensers, toilet flush sensors, incontinent sensors and fall sensors.

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Coverage will be limited to devices and technology not covered by other Medicaid programs and will be limited to the least costly option necessary to meet the service recipient's assessed need. Electronic back-up systems are not available to individuals living in settings that are required to provide these back-up systems for their residents as part of licensing requirements.

Technology will be provided by Medicaid enrolled provider or the state's approved purchasing guideline.

Relief Care:

Person-centered plan coordinators assist with identifying a regularly-scheduled relief care provider as part of the service plan or have identified back-up providers or care setting alternatives as part of the PCSP in case the participant's primary provider becomes ill or is suddenly no longer available. Additionally, individuals may utilize alternate service providers such as contracted in-home care agencies that can be employed on short notice if an individual cannot locate a Homecare Worker or Personal Support Worker who can meet their needs. Other licensed community-based service providers may be used to meet immediate care needs when an individual is unable to find a suitable provider to employ directly. Individuals can utilize 24 hour, home and community-based settings (such as FH/AFH/ALF/RCF/GCH, etc.) if they are unable to locate an in-home provider to meet immediate care needs. Local, state or contracted case management entities have access to Medicaid approved provider information for the state to assist individuals in selecting a provider from anywhere in the state.

Positive Behavioral Support Services:

Positive Behavioral Support Services are provided to assist individuals with behavioral challenges due to their disability, that prevent them from accomplishing ADL's, IADL's , and health related tasks. Positive Behavioral Support Services include coaching and support of positive behaviors, behavior modification and intervention supports to allow individuals to develop, maintain and/or enhance skills to accomplish ADL's, IADLs and health related tasks. The need for these services is determined through a functional needs assessment and the individual's goals as identified in the person centered planning process. Positive Behavioral Support Services may also include consultation to the care provider on how to mitigate behavior that may place the individual's health and safety at risk and prevent institutionalization.

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Services may be implemented in the home and/or community, based on an individual's assessed needs. All activities must be for the direct benefit of the Medicaid beneficiary.

Behavior Professionals will work with the individual and, if applicable, the caregiver, to assess the environmental, social, and interpersonal factors influencing the person's behaviors. The consultants will develop, in collaboration with the individual and if applicable, caregivers, a specific positive behavioral support plan to address the needs of the person to acquire, maintain and enhance skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living and health related tasks. These services do not include rehabilitation or treatment of mental health conditions. The provision of this service will not supplant the provision of personal attendant services that are based on the individual's assessed needs that are identified in the PCSP. Positive Behavioral Support Services are prior authorized based on the approved PCSP. Services are provided through Behavior Professionals approved by the Department or designee.

4. Voluntary training on how to select, manage, and dismiss attendants. Please identify who is performing these activities.

Individuals will be offered the opportunity to participate in training on how to manage their attendant services. As an example, the Oregon Home Care Commission (HCC) provides a voluntary training called the STEPS program that promotes successful working relationships between consumer-employers and homecare workers or Personal Support Workers. STEPS is a voluntary program offered statewide through the local Centers for Independent Living, Area Agencies on Aging or other not-for-profit organizations with the expertise to train eligible individuals. Individuals are informed of the training during service planning and are provided with information about the local contractor in order to register. The HCC also contacts individuals directly to offer the voluntary training.

All individuals will be offered the opportunity to participate in the training. The training will be offered on either a one-on-one basis or in a group format, depending on which format will meet the needs of the particular eligible individual. The training program will cover selection, management and dismissal of homecare workers and personal support workers.

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Topics will be specific to the individual but include: understanding the Person-centered Service Plan and Task List/Service Agreement, creating job descriptions, locating employees, interviewing and completing reference checks, training, supervising and communicating effectively with employees, tracking authorized hours worked, recognizing, discussing and attempting to correct any employee performance deficiencies, discharging unsatisfactory workers, and developing a back-up plan for coverage of services.

5. Support System Activities

The local, state or contracted case management entities, primarily through person-centered plan coordinators and state trained assessors, provide support system activities to individuals enrolled in CFC option. The activities provided by these entities include:

Assessment and counseling prior to enrollment in CFCO:

i. Information, counseling, training and assistance to ensure that an individual is able to manage the services.

ii. Information communicated to the individual in a manner and language understandable by the individual, including needed auxiliary aids and/or translation services.

iii. Support activities include the following:

i. Conducting person-centered planning
ii. Range and scope of available choices and options
iii. Process for changing the person-centered service plan
iv. Grievance process
v. Risks and responsibilities of self-direction.
vi. Free Choice of Providers
vii. Individual rights and appeal rights.
viii. Reassessment and review schedules
ix. Defining goals needs and preferences
x. Identifying and accessing services, supports and resources.

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xi. Development of risk management agreements.
xii. Development of personalized backup plan.
xiii. Recognizing and reporting critical events, including abuse investigations.
xiv. Information about advocates or advocacy systems and how to access advocates and advocacy systems.

Conflict of Interest Standards

The State assures that conflict of interest standards for the functional needs assessment and development of the person-centered service plan applies to all individuals and entities, both public and private. Oregon's Conflict of Interest Standards require an individual to publicly declare when a potential conflict of interest arises, prior to taking any action on behalf of the public. A public declaration describing the nature of the conflict is required if an actual conflict of interest has occurred. The State will ensure that the individuals conducting the functional needs assessment and person-centered service plan are not:

1) Related by blood or marriage to the individual, or to any paid caregiver of the individual.
2) Financially responsible for the individual.
3) Empowered to make financial or health-related decisions on behalf of the individual.
4) Individuals who would benefit financially from the provision of assessed needs and services.
5) Providers of State plan HCBS for the individual, or those who have an interest in or are employed by a provider of State plan HCBS for the individual.

Risk Management Plans

A risk assessment is conducted, in-person, for all individuals during the person-centered planning process. A risk management plan is developed for each individual and is detailed in the service plan. Person-centered plan coordinators must conduct risk assessments on an annual basis and the monitoring frequency as based on the level of risk determined during the assessment process. Person-centered plan coordinators use a risk assessment tools to determine the level of risk based on multiple risk factors: power outage/natural disasters, physical functioning, mental/emotional functioning, cognitive functioning, behavioral issues, income/financial issues, safety/cleanliness of the residence, whether the service plan meets the needs of the individual, the adequacy and availability of natural supports, and access to services.

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All individuals receiving services will be contacted at least quarterly throughout the year (minimum of 1 contact every three months). Individuals with three or more high risk factors must be contacted at least monthly. One of the contacts must be face-to-face while others may occur either by phone or other interactive methods, examples include but are not limited to, email or other secure methods, depending on the individual's preference and abilities.

The Department requires criminal background checks as a provider qualification and utilizes these background checks as a risk management tool. The Department assumes the cost of the background checks.

B. The State elects to include the following CFC permissible service(s):

1. X Expenditures relating to a need identified in an individual's person-centered plan of services that substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance. These include:

   Environmental Modifications. Environmental modifications are provided in accordance with 441.520(b).

   Assistive Devices. Assistive Devices means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living or instrumental activity of daily living. Coverage will be limited to devices and technology not covered by other programs and will be limited to $5000 per device or assistance based on an assessed need of the service recipient. Person-centered plan coordinators may request approval for additional expenditures through the DHS policy office prior to expenditure. Expenditures will only be made for the most cost effective device or assistance and must be approved by the Department for any expenditure over $1200.

   Community Transportation. Community Transportation is provided to eligible individual to gain access to community-based state plan and waiver services, activities and resources. Trips are related to recipient service plan needs, are not covered in the 1115 medical benefit, are not for the benefit of others in the household, and are provided in the most cost-effective manner that will meet needs specified on the plan. Community Transportation services are not used to: 1) replace natural supports, volunteer transportation, and other transportation services available to the individual; 2) compensate the service provider for travel to or from the service provider's home.

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Home-Delivered Meals (HDM). HDMs are provided for participants who live in their own homes, are home-bound, are unable to do meal preparation, and do not have another person available for meal preparation. Payment for HDMs will not be allowed when individuals are receiving CFC services in a setting where residential providers must provide meals. Home and community based residential providers must provide meal services. Provision of the home delivered meal reduces the need for reliance on paid staff during some meal times by providing meals in a cost-effective manner. Each HDM contributes an estimated one-third of the recommended daily nutritional regimen, with appropriate adjustments for weight and age. HDM providers bill the state Medicaid program directly for no more than one meal per day.

2. X Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides. These expenditures are limited to individuals transitioning from a nursing facility, IMD, or an ICF/ID to a home or community-based setting where the individual resides.

Service Limits

Service levels for home and community based services and allowable activities for in-home services are based on the individualized functional assessment of service needs. In-Home hourly allocation may be divided between support for ADLs, IADLs, and Health-Related Tasks. The following items will be based on the individual's functional assessment and identified as being unmet by other state plan services or natural supports:

- Assistance with Activities of Daily Living (ambulation, transferring, eating, cognition /behaviors, dressing, grooming, bathing, and hygiene), and
- Instrumental Activities of Daily Living (housekeeping, laundry, medication management, transportation, meal preparation, and shopping).

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Natural supports are identified during the person centered service planning process and utilized when available to the individual. Natural Supports are defined as resources available to an individual from their relatives, friends, significant others, neighbors, roommates and the community. Natural supports are determined to be available when an individual listed above is willing to voluntarily provide the identified services and the service recipient is willing to accept services from the natural support. If the natural support is unwilling or unable to provide the identified services, paid supports will be provided. This requirement does not require that caregivers that were previously unpaid should become paid caregivers under the CFC benefit, nor does this require that caregivers need to be paid beyond the paid hours authorized in the plan. Nothing in the natural support determination prevents the Department from paying qualified family members who are performing paid work. The state will not provide services or supports that are within the range of activities that a parent/legally responsible individual would ordinarily perform on behalf of a child without a disability or chronic illness of the same age.

Payment for home-delivered meals, chore services, home-care workers or personal support workers, personal emergency response systems, relief care providers, and environmental accessibility adaptations will not be allowed when they would duplicate other services provided under another benefit or program. Home and community based residential providers must ensure their residents have access to substantially similar services as those living in their own homes. Department contracted Community Nurses will provide services for individuals living in their own homes or Foster Homes. Payment for LTCCNS will not be allowed when individuals are receiving CFC services in other residential home and community based settings.

Health related tasks will be limited to a need or needs, identified through the functional assessment and reflected in the person-centered service plan.

Electronic back-up systems, mechanisms and any specialized or durable medical equipment necessary to support the individual's health or well-being will be limited to items approved in the services plan and are not to exceed $5,000 and payable only when other funding authorities such as Medicare, Medicaid or private insurance, disallow the item or service. Person-centered plan coordinators may request approval for expenditures beyond the limit through the DHS policy office prior to expenditure. Services must be the most cost-effective and approved by the Department.

Transition services will be limited to necessary services for individuals transitioning from an institution into a community-based or in-home program. Services will be based on an assessed need, determined during the person-centered service planning process and will support the desires and goals of the individual receiving services and supports. Final approval for expenditures will be through the DHS policy office prior to expenditure.

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Approval will be based on individual's need and the policy office's determination of appropriateness and cost-effectiveness. Financial assistance will be limited to: moving and move-in costs including; movers, cleaning and security deposits, payment for background/credit check (related to housing), initial deposits for heating, lighting and phone; and payment of previous utility bills that may prevent the individual from receiving utility services and basic household furnishing (i.e. bed) and other items necessary to re-establish a home. Individuals will be able to access the benefit no more than twice annually though basic household furnishing and other items will be limited to one time per year.

Environmental modifications are limited to $5,000 per modification. Person-centered plan coordinators may request approval for additional expenditures through the DHS policy office prior to expenditure. Approval will be based on individual's need and goals and the policy office's determination of appropriateness and cost-effectiveness. Environmental modifications must be tied to supporting ADLs, IADLs and health-related tasks as identified in the service plan. Modifications over $500 must be completed by a state licensed contractor. Any modification requiring a permit must be inspected and be certified as in compliance with local codes by local inspectors and filed in provider file prior to payment. Environmental modifications must be made within the existing square footage of the residence, except for external ramps, and cannot add to the square footage of the building. Payment to the contractor is to be withheld until the work meets specifications.

All services are expected to be provided in a person centered manner with a focus on including the eligible individual and promoting self-management of the health condition(s) whenever possible**.**

Exceptions to limits and service payments may be requested but will only be granted if DHS determines:

(a) The individual has service needs, documented in the service plan, that warrant an exception for hours or payment; and

(b) No alternative, in the least restrictive setting possible, is available to meet the needs of the individual.

Distinct service elements, procedure codes and claim modifiers will differentiate whether the services are State Plan K services or other Medicaid Services under 1915 (c) or other authorities. This will ensure that there is no duplication of services.

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iv. Use of Direct Cash Payments

a) ___ The State elects to disburse cash prospectively to CFCO participants. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

b) _X_ The State elects not to disburse cash prospectively to CFCO participants.

v. Assurances

(A) The State assures that any individual meeting the eligibility criteria for CFCO will receive CFC services.

(B) The state assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for CFCO services including adherence to section 1903(i) of the Act that Medicaid payment shall not be made for items or services furnished by individuals or entities excluded from participating in the Medicaid program..

(C) The State assures the provision of eligible individual controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life.

(D) With respect to expenditures during the first full 12 months in which the State plan amendment is implemented, the State will maintain or exceed the level of State expenditures for home and community-based attendant services and supports provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding 12month period.

(E) The State assures the establishment and maintenance of a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports.

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(F) The State assures the collection and reporting of information, including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a CFC the choice to instead receive home and community-based services in lieu of institutional care.

(G) The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this option during the fiscal year.

(ii) The number of individuals that received such services and supports during the preceding fiscal year.

(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a CFC.

(H) The State assures that home and community-based attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws consistent with 441.570(d)(1)-(5).

(I) The State assures it established a Development and Implementation Council prior to submitting a State Plan Amendment in accordance with section 1915(k)(3)(A). The council is primarily comprised of eligible individuals who are individuals with disabilities, elderly individuals and their representatives.

vi. Assessment and Service Plan

Level of Care assessments and functional needs assessments will occur prior to the development of the service plan. Person-centered plan coordinators or state trained assessors complete a functional needs assessment, which includes a comprehensive discussion with the participant about the participant's functional abilities and strengths in completing activities of daily living and instrumental activities of daily living. Individuals will be actively involved in the functional needs assessment process and will have the opportunity to identify goals, strengths and needs.

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They will be allowed to have anyone they would like participate in the assessment process. Person-centered plan coordinators will also discuss psycho-social elements and the availability of natural supports to assist in meeting needs. The Department uses assessment tools that measure individual needs surrounding ADLs and IADLs along with cognitive/behavior concerns. The assessment records individual needs and preferences regarding the individual's choice of how the services are to be provided, regardless of what funding mechanisms or supports are intended to meet the individual's needs.

All level of care assessments and reevaluations are conducted by person-centered plan coordinators or state trained assessors. DHS' minimum person-centered plan coordinators qualifications and state trained assessors' qualifications are:

- Bachelor's degree in a Behavioral Science, Social Science, or a closely related field; OR
- Bachelor's degree in any field 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
- Associate's degree in a Behavioral Science, Social Science or a closely related field AND two 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); 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);
- In addition to the above, state trained assessors responsible for completing assessments must meet initial and ongoing training requirements provided by DHS.

To meet Nursing Facility LOC, individuals must be assessed as meeting at least one of the following priority levels as defined in OAR 411-015-0010 to meet the nursing facility level of care criteria:

(1) Requires Full Assistance in Mobility, Eating, Elimination, and Cognition.

(2) Requires Full Assistance in Mobility, Eating, and Cognition.

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(3) Requires Full Assistance in Mobility, or Cognition, or Eating.

(4) Requires Full Assistance in Elimination.

(5) Requires Substantial Assistance with Mobility, Assistance with Elimination and Assistance with Eating.

(6) Requires Substantial Assistance with Mobility and Assistance with Eating.

(7) Requires Substantial Assistance with Mobility and Assistance with Elimination.

(8) Requires Minimal Assistance with Mobility and Assistance with Eating and Elimination.

(9) Requires Assistance with Eating and Elimination.

(10) Requires Substantial Assistance with Mobility.

(11) Requires Minimal Assistance with Mobility and Assistance with Elimination.

(12) Requires Minimal Assistance with Mobility and Assistance with Eating.

(13) Requires Assistance with Elimination.

Levels are determined as a result of a comprehensive assessment, conducted by a person-centered plan coordinator, using an electronic tool called the Client Assessment and Planning System (CAPS). This assessment documents a person's abilities and limitations in areas of activities of daily living (ADL) and instrumental activities of daily living (IADL). It also collects information about living environments, personal characteristics and preferences, treatments and general health history. Using a programmed algorithm, CAPS then calculates an individual's priority for receiving services based upon the degree of assistance an applicant requires with specific activities of daily living. This assessment tool is used to determine Level of Care for both home and community based care and nursing facility care.

Children being assessed for NF LOC are assessed using the Medically Involved Clinical Criteria tool as defined in OAR 411-300-0020. The clinical criteria tool scores based on needs for the child that are outside of the school setting. The assessment factors in age appropriate care needs when reviewing ADL and IADL abilities and limitations. The tool also factors in paramedical interventions that may be needed. These are areas that require physician's orders or RN delegation. The assessment scores points based on the intensity of assistance needed and severity and intensity of medical interventions.

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In order to meet the ICF/ID level of care, an individual must meet eligibility criteria as described in OAR 411-320-0080 for intellectual disability or developmental disability other than intellectual disability and have significant impairment in adaptive behavior. State trained assessors complete the initial LOC assessment. State trained assessors or person centered plan coordinators review the level of care annually, or more frequently based on the functional needs of the individual, or at the request of the eligible individual. The assessments happen during a face-to-face meeting with the individual. The state trained assessor or person-centered plan coordinator completes the assessment using personal observations of the individual, interviews with the individual and others with personal knowledge of the individual, and documentation of the individual's functioning from information in the individual's file, such as standardized tests administered by qualified professionals.

Once the state trained assessor completes the initial LOC they submit it to DHS.

DHS employs a Diagnosis and Evaluation Coordinator (D & E Coordinator), to assist with oversight and training person-centered plan Coordinators.

A component part of the LOC assessment is to confirm:

That the individual meets eligibility criteria of a person with an intellectual with an intellectual disability or a closely related condition as well as functional impairments as a result of the condition. The determination is based on the diagnosis and functional impairments (whether the individual has substantial limitations in the six areas of major life activity identified by CMS in the definition of persons with related conditions in 42 CFR §435.1010 (self-care; understanding and use of language; learning; mobility; self-direction; and capacity for independent living".

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The Department uses a LOC tool that indicates impairments are explicitly related to eligibility. Additionally, eligibility specialists sign an attestation verifying the eligibility as intellectually disabled or developmentally disabled under
OAR 411-320-0080. The diagnostic area will include additional information regarding the individual's qualifying diagnosis, and IQ and adaptive impairment scores used to make the determination.

All individuals considered for the Hospital Level of Care are assessed using the Level of Care assessment form and MFCU clinical criteria. The MFCU Clinical Criteria combined with the Level of Care Assessment Form are the complete level of care evaluation. The Clinical Criteria tool assesses and scores various care elements that the assessor expects to last six months or more. It measures nursing and other intervention needs, factoring in frequency and intensity of the care needed in the following: Skin/Physical Management; Metabolic: GI/Feeding; Neurological; Urinary/Kidney; Respiratory; and Vascular. Individuals must have a physician's signature that hospital level of care is required.

Person-Centered Service Plan Requirements:
The person-centered service plan will reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. The plan must:
(1) Reflect that the setting in which the individual resides is chosen by the individual.
(2) Reflect the individual's strengths and preferences.
(3) Reflect clinical and support needs as identified through an assessment of functional need.
(4) Include individually identified goals and desired outcomes.
(5) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports.

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(Natural supports cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual.) This requirement does not require that caregivers that were previously unpaid should become paid caregivers under the CFC benefit, nor does this require that caregivers need to be paid beyond the paid hours authorized in the plan.
(6) Reflect risk factors and measures in place to minimize them, including individualized backup plans.
(7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her.
(8) Identify the individual and/or entity responsible for monitoring the plan.
(9) Be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation.

Person-Centered Service Plan Development Process: Local, state or contracted case management entities have the responsibility for determining the individual's level of care, performing a functional needs assessment and developing a person-centered service plan in accordance with the individual's choice of services to be provided. The service planning process includes evaluating all available resources and funding mechanisms to meet the individual's needs. A primary goal is to develop a person-centered service plan that identifies strengths, desires, goals and existing supports and to develop a comprehensive plan that honors the dignity, strength and autonomy of the individual and that supports their right to be as integrated in the community as they choose.
The individual or designated representative decides who may or may not be included in person-centered service plan development discussions and contribute to the individual's person-centered service plan. Person-centered plan coordinators assist the individual in selecting and notifying other participants in the assessment and planning process. Person-centered plan coordinators meet with each individual (and family or representative, as appropriate) on a schedule that assures eligibility determinations and assessments are completed within 45 days of request of services.

The person-centered plan coordinator must address the needs of the participant through the PCSP and provide the participant a copy of the plan. The eligible individual will have the opportunity to review and modify the plan. The person-centered plan coordinator will work with the individual to identify the individual's goals, needs and preferences for the way that services are provided and received. Local, state or contracted case management entities give individuals information about the array of options available to them and provide choice counseling. The person-centered plan coordinator will ensure that providers have a copy of the relevant tasks from the service plan for which they are responsible.

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The person-centered plan coordinator will consult with service providers and the individual throughout the assessment process to review and verify the appropriate services are being offered, performed and are still appropriate for the individual. This ongoing dialogue will ensure that any changes in condition or service choice allow for the assessment to be reviewed for appropriateness as quickly as possible. Local, state or contracted case management entities inform participants/ representatives about service options at changes in conditions and when the participant is transitioning from one care-setting to another.

Local, state or contracted case management entities assist with health care coordination and may make referrals to contracted LTCCNS Nurses, including delegation of some nursing tasks and teaching, training and monitoring on a variety of health-related topics. The state will provide Long-term Care Community Nursing Services (LTCCNS) to support health related tasks within the state's nurse practice act. These services include nurse delegation and care coordination for eligible individuals. This service does not include direct nursing care and the services are not covered by other Medicaid spending authorities. All other licensed providers must have nursing staff available for delegation, teaching and training.

Each plan will address the eligible individual's choice for the type of services they receive, the service provider and location of the service delivery. Choice is a critical aspect in the person-centered service plan.

Each plan includes the type of service to be provided, the amount, frequency and duration of each service, and the type of provider to furnish each service. Since the plan is built in conjunction with the assessment of needs, it may be developed simultaneously with determination of level of care and eligibility for CFC services or shortly after, allowing time for researching and reviewing available natural supports, providers and service options.

An in-home service plan is implemented when a qualified provider is identified, the qualified provider's service start date is set and the authorized hours of services are determined. A plan for facility services is implemented as soon as the individual chooses and moves into a community-based facility. The individual has the right to request changes in qualified provider and living situation. A change in plan will be implemented as soon as an alternate plan can be developed. Person-centered plan coordinators will meet with the individual (and family or representative, as appropriate) at least annually to review and update the PCSP.

Local, state or contracted case management entities coordinate services for participants who reside in facilities in cooperation with facility staff at the direction of the individual. The person-centered plan coordinator communicates with facility staff on a regular basis and may participate in facility care conferences. These care conferences are distinct from the functional assessment, person-centered plan development process and other direct communication with the individual and their representative.

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Person-centered plan coordinators inquire and identify risks such as environmental hazards that may jeopardize safety or health. For participants living at home or in some foster homes, person-centered plan coordinators gather information about emergency plans in the event of a natural disaster. Administrative Rules require Community-Based facility providers to prepare emergency plans for response to natural disasters.

The State assures that conflict of interest standards for the functional needs assessment and development of the person-centered service plan applies to all individuals and entities, both public and private. The State will ensure that the individuals conducting the functional needs assessment and person-centered service plan do not have a conflict of interest.

vii. Home and Community-based Settings

CFC Services will be provided in a home or community setting, which does not include a nursing facility, hospital providing long-term care services, institution for mental diseases, or an intermediate care facility for the intellectually disabled. Settings will include the individual's home or in the community. Licensed, Certified or Endorsed Community-based settings include-

Assisted Living Facility (ALF)
Adult Foster Care (AFC)
Adult Day Center
Day Habilitation Provider
Residential Care Facilities (RCF)
Residential Treatment Facility/Home for Mentally or Emotionally Disturbed Persons
Supported Living Providers
Adult Group Home (GCH)
Group Care Homes for Children (GCH)
Developmental Disabilities Adult Foster Care
Children's Developmental Disability Foster Care
Children's Developmental Disability Host Home

Licensed or certified community-based settings maintain the following characteristics:

a. The setting is integrated in, and facilitates the individual's full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, in the same manner as individuals without disabilities;

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Individuals will have the ability to choose from services in their own home, a family home, or in a licensed setting. By statute, all licensed settings are integrated into communities. Individuals have the ability to fully engage in their community including engaging in any community activity such as seeking/retaining employment, social activities, religious services and community events. Providers in licensed settings are to provide or arrange for transportation if the individual cannot. Individuals retain control over their personal resources unless they have chosen not to or have been determined by the courts or the Social Security Administration to be unable to manage their personal resources.

Through regular visits with the individual, occurring no less frequently than annually, person-centered plan coordinators ensure that individuals have access to the greater community and have the opportunity to engage in community life and control their own resources. Licensing staff ensure compliance with statutes, regulations and rules that ensure that providers do not impinge on the liberties of the individuals residing in the facility. OAR specifies services that must be provided for residents. Additionally, residents receiving CFC services in CBC residential settings all have resident rights and protection under Oregon Revised Statute Chapter 443.

Oregon statute allows for the State to determine the location of residential facilities: ORS 443.422 Siting of licensed residential facilities. (1) To prevent the perpetuation of segregated housing patterns, the Department of Human Services, in consultation with the Oregon Health Authority, shall determine the location and type of licensed residential facilities and the location of facilities subject to the provisions of ORS 169.690.

b. The setting is selected by the individual from among all available alternatives and is identified in the person-centered service plan;

While developing the service plan for each individual, the person-centered plan coordinators fully informs individuals of all of the many choices that are available to them. If an individual chooses a licensed setting, the person-centered plan coordinator provides information about each of the licensed settings available to the individual. Individuals may review and tour as many settings as they would like anywhere in the state. The individual selects the provider of their choice. Person-centered plan coordinators enter the choice into the person-centered service plan.

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c. An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;

d. Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented

For both c. and d. above, all Community Based Care Residential Providers are required by Oregon Revised Statute (ORS) and Oregon Administrative Rules (OARs) to comply with and post in a prominent location the Resident Bill of Rights. The Resident Bill of Rights in each setting ensure, at a minimum, privacy in their personal interactions and communications, dignity, respect, personal choice, rights to grieve without fear of retaliation, and freedom of abuse, neglect and discrimination.

OARs provide that restraints can only be used in the case of an emergency to protect the individual or other individuals and defines abuse which may include involuntary seclusion and wrongful restraint. Neither seclusion nor restraint may be used for discipline or convenience of the provider and must be part of a defined plan to address the safety of the individual or other residents.

e. Individual choice regarding services and supports, and who provides them, is facilitated.

Individuals have full choice regarding the services and supports they receive and who provides those services. Person-centered plan coordinators have access to a full range of qualified providers which they share with the individual. Person-centered plan coordinators assist individuals in locating appropriate providers. Person-centered plan coordinators also assist individuals in identifying and mitigating risks associated with the individual's choice. Frequent site reviews monitor compliance with this expectation.

1. The unit or room is a specific physical place that can be owned, rented or occupied under another legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the State's landlord tenant law of the State, county, city or other designated entity.

Individuals living in licensed care settings have rights substantially similar to individuals renting their own apartment or house.

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In the majority of situations providers may not transfer or move out an individual without 30 days written notice. An individual may only be asked to leave involuntarily for medical reasons, or for the welfare of the resident or other residents, or for nonpayment. Each individual has an opportunity for a hearing. A licensee may give less than 30 calendar days' notice ONLY if undue delay in moving the resident would jeopardize the health, safety, or well-being of the resident, the resident exhibits behaviors that pose an immediate danger to self or others, or the resident is hospitalized or is temporarily out of home and the provider determines that they will not be able to meet the needs of the individual when they return.

2. Each individual has privacy in their sleeping or living unit:

Individuals have privacy in their living and/or sleeping unit unless the person-centered service plan identifies a risk to such privacy (i.e., severe self-injurious behaviors or uncontrolled seizures.). Individuals have the ability to furnish their sleeping or living unit. The goal is to serve people in the most home-like setting possible based on their person-centered service plan, rather than traditional congregate settings. Some settings may have individual bathrooms attached to the living or sleeping unit, and others may not. Individuals, whose person-centered service plan does not indicate risks, will be able to choose from all available options including those with lower and higher levels of privacy. The critical choice occurs before an individual chooses a specific setting. If privacy, such as an individual bathroom attached to the living unit is important to the individual, they will select a provider that offers such amenities. Person-centered plan coordinators will assist individuals in locating a provider that meets their particular needs and wants.

Foster Homes and RCFs are home-like settings that may or may not have the highest level of privacy since the fundamental concept is to model traditional family homes as much as possible. ALFs have the highest level of privacy available with private bathrooms. Regardless, individuals have the right to privacy in all settings and the inherent dignity and respect will be honored. A primary driver is to ensure that individuals have as much control over their life as possible.

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3. Units have lockable entrance doors, with appropriate staff having keys to doors;

The goal is to serve people in the most home-like setting possible rather than traditional congregate settings. Individuals, whose person-centered service plan does not indicate risks, will be able to choose from all available options including those with locks on the living or sleeping units. The critical choice occurs before an individual chooses a specific setting. If locked living or sleeping units are important to the individual, they will select a provider that offers locks. Person-centered plan coordinators will assist individuals in locating a provider that meets their particular needs and wants.

Foster Homes and RCFs are home-like settings that may or may not have locks on bedroom doors. ALFs have locking units with appropriate staff having keys. Regardless of locks, individuals have the right to privacy. If an individual would like a lock on their unit, and their person-centered plan does not indicate that this would endanger the individual, the request will be honored.

4. Individuals share units only at the individual's choice;

Some of the community-based care settings have two person rooms. An individual is made fully aware of this before they select that particular provider or setting. Assisted Living Facilities provide self-contained, individual living units in which each resident has full choice of living alone or with a roommate and whom that roommate is. Individuals have free choice in the type of setting and the specific provider they want to choose to deliver their services. Individuals in shared living settings, such as some RCFs and Foster Homes, always get to choose if they would like to have a roommate or choose a setting and provider in which they can have their own bedroom or share. The individual always has other options available to them. Person-centered plan coordinators will assist individuals in locating a provider that meets their particular needs and wants.

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5. Individuals have the freedom to furnish and decorate their sleeping or living units.

All community based care facilities create environments that are as home-like as possible. This includes the ability of the individual to decorate and furnish their bedrooms and/or living units. The only limitations allowed are limitations to protect the individual from health and safety standards, protect the integrity of the building structure, or the safety of other residents.

6. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;

Individuals have full access to and the ability to participate in activities of social, religious, and community groups. Meals are usually addressed on a facility by facility basis though residents have access to food whenever they choose except when contraindicated by their specific condition (such as those with Pica). Limits are defined in the person-centered plan. Snacks are available upon request. Individuals may have their own food and eat whenever they choose. Food must be stored safely.

Facilities must provide diets that are appropriate to residents' needs and choices. The facility must encourage residents' involvement in developing menus. Menus must be prepared at least one week in advance, and must be made available to all residents. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. Individuals will have access to appropriate snacks provided by the facility. Individuals who would like other food may have access to their own food unless this causes a safety risk for themselves or other residents.

Resident Bill of Rights requires freedom to participate and choose social activities. Community based care residential provider types are required to facilitate and provide activities for which individuals can choose to participate. Individuals, whose person-centered service plan does not indicate a need for restrictions, can leave at any time to access the community.

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Person-centered plan coordinators work with the individual to ensure that their freedom and choices are being honored.

7. Individuals are able to have visitors of their choosing at any time;

Individuals have the ability to choose their visitors and when their visitors come to see them. Individuals may choose when their visitors are allowed to visit. Providers may discuss social covenants about the timelines to minimize disruption and negative impacts to other residents. Regardless, of these social covenants, providers must not limit visitors for their convenience.

Individuals are encouraged to maintain the maximum level of control possible while acknowledging that the individuals are sharing living space with other individuals. Restrictions must not be for the convenience of the provider and must be in the best interest of all residents or based on necessary restrictions identified in the person-centered plan. Facilities may limit access to visitors who are disruptive, violent or have a history of committing illegal activities.

8. The setting is physically accessible to the individual.

All facilities must be physically accessible to the individuals they serve.

Provider owned or controlled residential settings are not:

a. Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment.

b. Located in a building on the grounds of or immediately adjacent to a public institution

c. Located in a building on the grounds of or immediately adjacent to disability-specific housing.

The state will follow approved Statewide Settings Transition Plan. Oregon assures that the setting transition plan included with this 1915(k) State Plan Amendment will be subject to any provisions or requirements in the State's approved Statewide Settings Transition Plan. The State will implement any applicable required changes upon approval of the Statewide Settings Transition Plan and will make conforming changes to its 1915(k) State Plan Amendment, as needed, when it submits the next amendment. The most recent version of the Statewide Settings Transition Plan can be found at: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCBS/Pages/Transition-Plan.aspx

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viii. Qualifications of Providers of CFCO Services

Adult Day Providers- Licensing and certification requirements are OAR 411-066-0000 through 411-066-0015. Adult Day Service (ADS) programs that contract with the Department to provide services must be certified.

Adult Foster Care- Licensing requirements at OAR 411-050-0600 – 0690 OAR 309-040-0030 through 309-040-0330; and 411-360-0010 through 411-360-0310. Local CDDPs, Branch offices, DHS Central Office, and OHA/HSD are responsible for verification of provider qualifications upon initial license and annual renewal.

Adult Group Home- Contracted and State Operated Licensing requirements at OAR 411-325-0010 through 411-325-0480 and agency certification requirements at OAR 411-323-0010 through 411-323-0070. DHS Central Office is responsible for verification of provider qualifications biennially.

Assisted Living Facility- Licensing requirements at OAR 411-054-0000 - 0300. The DHS Client Care Monitoring Unit is responsible for verification of provider qualifications at initial license and renewal (every 2 years).

Behavior Support Service Providers- Behavior consultants are certified by the state or approved by a Department Designee. The Department is responsible for verification of provider qualifications initially and at least every 5 years.

Children's Developmental Disability Foster Care- Certification requirements at OAR 411-346-0100 through 411-346-0230 or 413-200-0300 through 413-200-0396. DHS, Office of Developmental Disabilities Services (ODDS) or Child.

Children's Developmental Disability Host Home—

Children's Developmental Disability Host Homes Programs are certified and endorsed by the state. DHS Central Office is responsible for verification of provider qualifications initially and biennially thereafter.

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Welfare, will determine compliance based on receipt of the completed application material, an investigation of information submitted, an inspection of the home, a completed home study and a personal interview with the provider. Certification requirements are reviewed biennially.

Community Nursing Services – Providers are enrolled Medicaid providers that are licensed registered nurses, licensed Home Health agencies; or Licensed In-Home agencies. Providers meet minimum requirements established in OARs including passing a criminal background check and having minimum direct care experience in LTC programs.

Community Living Supports Agency Provider- Providers are certified under OAR Chapter 411, Division 323 and endorsed to requirements described in OAR Chapter 411, Division 450. People providing direct services to a recipient must pass a Criminal History Check conducted by the state at a minimum of every two years. The agency must demonstrate proof of liability and operational insurance coverage as described in OAR 411-323-0030(3)(d). DHS verifies the qualifications of the provider every 5 years. Additionally, the Department can review at any time for cause. These providers are authorized to provide ADL, IADL and health related tasks during the course of attendant care, skills training, and relief care supports.

Community Transition Service Providers- Provider requirements at OAR 461-155-0526 Branch offices are responsible for verification prior to authorizing service and payment **Community Transportation, Individual provider**- Providers are enrolled Medicaid providers. Valid Oregon Driver's License is required. Individuals providing transportation must be at least 18 years of age, have a valid driver's license, a good driving record, and proof of insurance. People providing direct services to a recipient must pass a Criminal History Check conducted by the state. People providing direct services in the family home or working alone with a recipient must be at least 18 years of age; have ability and sufficient education to follow oral and written instructions and keep simple records; have training of a nature and type sufficient to ensure that the person has knowledge of emergency procedures specific to the individual being cared for; understand requirements of maintaining confidentiality and safeguarding individual information; display capacity to provide good care for the individual; and have the ability to communicate with the individual. With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

Community Transportation, Bus/Taxi- Transportation provided by common carriers, taxicab or bus will be in accordance with standards established for those entities.

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Community Transportation, Agency Provider- Licensing and certification requirements at OARs 411-325-0010 through 411-325-0480; ; 309-035-0100 through 309- 035-0190; OARs 309-041-0550 through 309-041-0830; 411-345-0010 through 411-345-0300; 411-360-0010 through 411-360-0310; 411-328-0550 through 411-328-830; 411-346-0100 through 411-346-0230; 411-450-0080. People providing transportation must also have a valid driver's license, a good driving record, and proof of insurance. With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

Developmental Disabilities Support Services Provider Organization- Providers are certified under OAR 411-323-0010 through 411-323-0070 and endorsed to requirements at OAR 411-340-0030, OAR 411-340-0040, OAR 411-340-0050, OAR 411-340-0070, OAR 411-340-0080, and OAR 411-340-0090, and OAR 411-340-0170. DHS verifies the qualifications of the provider at the time of the initial certification and every 5 years. Additionally, the department can review at any time for cause.

Group Care Homes for Children- Certification requirements at OAR 411.349-0000 through 411-3490020; 411-325-0010 through 411-325-0480; or 413-215-0000 through 413-215-0883. DHS Central Office is responsible for verification of provider qualifications biennially.

Habilitation Agency Provider - Providers are certified and endorsed under OARs 411-345-0000 through 411-345-0300 and OAR 411-323-0010 through 411-323-0070. People providing direct services in the family home or working alone with a recipient must pass a Criminal History Check conducted by the state at a minimum of every two years.

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Demonstrate proof of liability and operational insurance coverage as described in OAR 411-323-0030(3) (d). DHS verifies the qualifications of the provider every 5 years. Additionally, the department or the can review at any time for cause. These providers are authorized to provide ADL, IADL and health related tasks during the course of community living and inclusion supports and alternative to employment services.

Home Care Worker- Certification requirements at OAR 411-031-0020 - 0050. Branch offices are responsible for verification of provider qualifications at initial authorization. Criminal background checks are conducted initially and every 2 years.

In-Home Care Agency- Licensing requirements at OAR 333-536-0000 through 0100 and OAR 411-030-0002 through 0090. DHS Central office is responsible for verification of provider qualifications upon the execution and renewal of contracts.

Personal Support Worker- Requirements for qualification at OAR 411-375-0020. The Department is responsible for verification of these provider qualifications. Criminal background checks are conducted initially and every 2 years. . Personal Support Workers providing transportation must also have a valid driver's license, a good driving record, and proof of insurance as verified by the CDDP, Brokerage, or the Department. A representative of the CDDP, brokerage, the Department or family will verify that the person can provide the care needed by the individual. The common law employer (employer of record) is responsible for informing and training regarding the specific care needs of the individual. With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

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Local Transportation Authorities- DHS/Provider contract specifications. DHS Central Office is responsible for verification of provider qualifications upon execution of renewal of contracts. Contracts are renewed every 2 years.

Residential Care Facilities- Licensing requirements at OAR 411-054-0000 - 0300. The DHS Client Care Monitoring Unit is responsible for verification of provider qualifications at initial license and renewal (every 2 years).

Residential Treatment Facility for Mentally or Emotionally Disturbed Persons- License Licensed by the Oregon Health Authority under OAR 309-035-0110. Licenses are renewed every two years.

Skills Trainers- are hired or monitored by licensed, certified or specialty programs including Adult Foster Care, Adult Group Homes, Assisted Living Facilities, Community Living Supports Providers, Developmental Disabilities Support Services Provider Organizations, Group Care Homes, Habilitation Agency Providers, In-home Care Agencies, In-Home Support Provider Agency, Residential Care Facilities, Residential Treatment Facilities/Homes Specialized Living Services and Supported Living Agency providers that have demonstrated expertise in serving the targeted individuals.

Specialized Living Services- Certification requirements at OAR 411-065-0000 through 0050. Branch offices are responsible for verification of provider qualifications prior to executing a contract and annually thereafter. These service providers are authorized to provide ADL, IADL and health related tasks as well as acquisition services.

Supported Living Agency Provider - Providers are certified and endorsed under OARs 411-328-0550 through 411-328-0830 and OAR 411-323-0010 through 411-323-007. People providing direct services in the recipient's home or working alone with a recipient must pass a criminal history check conducted by the state at a minimum of every two years. The agency must demonstrate proof of liability and operational insurance coverage as described in OAR 411-323-0030(3) (d). Provider qualifications must be rechecked every 5 years. Additionally, the department or the CDDP can review at any time for cause.

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ix. Quality Assurance and Improvement Plan

The DHS Quality Assurance Teams (QAT) and policy staff members review and monitor the accuracy and consistency of operational and administrative functions performed by all state and local contracted entities through an ongoing process. Within a two year time frame, all state and contracted entities are fully reviewed. State and contracted entities also develop management plans that support key quality strategies and to address areas of concern: such as timeliness, accuracy, appropriateness of services, services billed are actually received, compliance with State and Federal regulation, program outcomes, eligible individual satisfaction and cost effectiveness.

The process of evaluation involves Quality Assurance Team examination of a sample of participant cases through review of data stored in electronic databases, review of case files on-site, and individual interviews that include an assessment of eligible individual satisfaction.

The QA Team records findings using program specific standardized tools and issues a formal finding in a report to the state or contracted entity identifying trends in policy and rule application. The state or contracted entity must submit a plan of correction to DHS within 30 days of receipt of this report that addresses any issues found in the QA Team report. DHS then issues a final report to the state or contracted entity. The Quality Assurance team revisits the state or contracted entity to follow-up with the written corrective action plans to ensure compliance and remediation of any issues addressed in the final report.

The assessment methods used by the QA Team include file reviews, onsite reviews, interviews and assessments with individuals receiving services, and service plan reviews.

Oregon has implemented the National Core Indicators project. The project gives the Department information from eligible individual's perspectives about Developmental Disabilities services. Oregon has implemented a system (Aspen) allowing the Office of Licensing and Regulatory Oversight increased access to information for licensing and quality assurance activities.

The Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) is an internal leadership and governance body of OHA and DHS, chartered in accordance with the Inter-Agency Agreement (IAA). MOCSC is co-chaired by representatives of OHA and DHS appointed by the OHA/DHS Joint Operations Steering Committee (JOSC).

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The MOCSC provides high level oversight and decision-making on the operations of the Medicaid/CHIP programs and monitors the interagency agreements between DHS 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 DHS 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 JOSC or the Medicaid/CHIP Policy Steering Committee/Joint Policy Steering Committee (JPSC) that link the business objectives of OHA and DHS (and the joint administrative processes applicable to Medicaid/CHIP programs operational and business processes) and may significantly affect both agencies
- 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; and
- Referring concerns or disagreements related to decisions by the MOCSC to JOSC or JPSC as appropriate.

The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

The SPA application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- **Participant Access**: *Individuals have access to home and community-based services and supports in their communities.*
- **Participant-Centered Service Planning and Delivery**: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*

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- **Provider Capacity and Capabilities**: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- **Participant Safeguards**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- **Participant Rights and Responsibilities**: *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- **Participant Outcomes and Satisfaction**: *Participants are satisfied with their services and achieve desired outcomes.*
- **System Performance**: *The system supports participants efficiently and effectively and constantly strives to improve quality.*

System performance measures, outcome measures and satisfaction measures include the following:

1. The percentage of CFC applicants for whom state or local contract staff has completed a level-of-care assessment to determine institutional level of care eligibility prior to enrollment. Numerator = number of enrolled applicants who have a completed level of care assessment. Denominator = total number of files reviewed of enrolled applicants for CFC services.

2. The percentage of CFC participants whose CFC eligibility was determined using the appropriate processes and instruments and according to the approved description. Numerator: CFC participants whose CFC eligibility was determined using the appropriate processes and instruments according to the approved description. Denominator: All files reviewed of CFC participants found eligible for services.

3. The percentage of providers of CFC services plan that meet required licensure and/or certification under Oregon Administrative Rule. Numerator: Providers that prior to delivering CFC services initially met and continue to meet licensure and/or certification requirements. Denominator: All files reviewed in which providers delivering CFC services require licensure and/or certification.

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5. The percentage of providers who are trained per Oregon Administrative Rules and the approved CFC. - Numerator: CFC service providers that are trained per Oregon Administrative Rules and the approved CFC. - Denominator: All CFC services provider for files reviewed.

6. The percentage of participants whose service plans address assessed needs and personal goals per approved procedures. Numerator: Participants whose service plans address assessed needs and personal goals per approved procedures. Denominator: All CFC participant service plans reviewed.

7. All participants have a written and authorized service plan in accordance with Oregon Administrative Rules. Numerator: All participants with a written and authorized service plan in accordance with OAR. Denominator: All participants' service plans reviewed.

8. The percentage of service plans that are updated or revised annually. Numerator: Plans that are renewed within 12 months from the previous service plan. Denominator: All service plans reviewed.

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

10. The percentage of services delivered in accordance with what is specified in the service plan including the type, scope, duration and frequency. Numerator: Service plans for which services delivered are in accordance with the type, scope, duration and frequency specified in the plan. Denominator: All service plans reviewed.

11. Individuals are offered the choice of CFC services and offered choice of qualified providers. Numerator: Participants who are offered choice of CFC services and qualified providers. Denominator: All CFC participants reviewed.

12. Individuals are offered the choice between CFC services and institutional care. Numerator: Number of participants offered the choice between CFC services and institutional care. Denominator: All CFC services recipients reviewed.

13. The percentage of participants who are victims of substantiated abuse, neglect or exploitation. Numerator: Participants who are victims of substantiated abuse, neglect or exploitation. Denominator: All CFC participant files reviewed.

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14. Identified individual risk and safety considerations are addressed taking into account the individual's informed and expressed choices. Numerator: Identified risks and safety considerations addressed taking into account the individual's informed and expressed choices. Denominator: All CFC participant files reviewed.

15. The percentage of claims that are authorized and paid for in accordance with reimbursement specified in the approved CFC. Numerator: Reimbursements that are authorized and paid for in accordance with the methods specified in the approved CFC. Denominator: All reimbursements for files reviewed.

16. Percent of individuals who express that their services and supports are meeting their needs. Numerator: Number of service recipients who express their service needs are being met. Denominator: All service recipients who respond to the satisfaction survey.

18. Percent of individuals who express that they are able to direct their services. Numerator: Number of service recipients who express they are able to direct their services. Denominator: All service recipients who respond to the satisfaction survey.

Measurement of individual outcomes associated with the receipt of community-based attendant service and supports.

Every two years, DHS will survey statistically valid sample of individuals receiving CFC services to determine their satisfaction and outcomes related to the CFC services. The survey will include an assessment of the individual's opinion in progress towards goals identified by the individual in their person-centered service plan. The survey will also address the quality of care about the service provider. DHS will monitor length of stay in the service setting to determine the stability of the person-centered service plan.

DHS shall ensure that all individuals receiving CFC services and supports have access to all of the protections in the state's abuse, neglect and exploitation protection including mandated reporting, investigation and resolution of allegations of neglect, abuse, and exploitation. Oregon law defines mandatory reporters, types of abuse and consequence and remediation in appropriate cases. DHS shall follow these statutes and the corresponding administrative rules. In addition to abuse reports required by statute for older adults, people with developmental disabilities and people with mental illness, all staff shall report abuse for individuals under age 65. Protective service workers will investigate any allegation.

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Standards for service delivery models for:

Training

Each provider type has specific training requirements described in Oregon Administrative Rule, as listed in the provider qualifications. Provider training may be provided by DHS, professional associations and independent trainers. Trainings are targeted to individuals, to specific provider types and delivery systems to ensure that the special needs of any particular population are addressed effectively. Person-centered plan coordinators receive training that includes formal training curriculum on person centered planning and philosophy and other critical case management activities. Person-centered plan coordinators and state trained assessors receive initial and ongoing training. Training includes working with consumers, eligibility, how to lead a functional needs assessment with the consumer, person-centered planning, choice counseling to ensure free choice of providers and service settings, service options and delivery systems, protective services, addressing needs of special populations.

Denials and Reconsiderations

DHS has standardized forms and processes for informing individuals/ representatives of rights, recording hearing requests, completing pre-hearing summaries, conducting hearings, and notifying individuals/representatives of the hearing outcomes.

DHS communicates additions or revisions to forms and processes to local, state or contracted case management entities through formal electronic transmittals.

Individual service recipients and applicants, and their representatives, are provided timely written notice of any planned change in services or benefits, including denial, closure or reduction. For denials, the time frame is 45 days from the date of application. For closure or reduction of benefits or services the time frame is 10 working days prior to the effective date of the proposed action. The notice includes the reason for DHS' decision, administrative rules that support the decision and the individual's/representative's right to due process through an administrative hearing process.

Appeals

The local, state or contracted case management entity notifies the individual about the Fair Hearing process during the initial assessment/service planning. As part of the notification of Fair Hearings procedure, the person-centered plan coordinator informs the individual that continuation of services must be requested by the individual under the timeframes specified in OAR.

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Results of the hearing are provided to the individual in the form of a Hearing Order written by the Administrative Law Judge. The Hearing Order is mailed to the individual.

Describe the quality assurance system's methods that maximize consumer independence and control and provide information about the provisions of quality improvement and assurance to each individual receiving such services and supports.

Local, state or contracted case management entities fully inform individuals of all available choices and service options. Documentation requirements and automated systems support quality assurance efforts. The QA processes defined above includes ensuring that individuals were fully informed of their options and their ability to direct their own service plan. This is monitored by eligible individual satisfaction surveys. QA teams meet with individuals receiving services in each local office audit to ensure eligible individual choice was offered and honored.

Describe how the State will elicit feedback from key stakeholders to improve the quality of the community-based attendant services and supports benefit.

The Department has established Development and Implementation Council, the majority of which is comprised of individuals with disabilities, elderly individuals and their representatives. The Department consults and collaborates with the Council on a regular basis to inform and elicit feedback regarding the services and supports provided to individuals receiving CFC services.

The methods used to continuously monitor the health and welfare of Community First Choice individuals

local, state or contracted case management entities regularly monitor service plans to ensure the health and welfare of individuals receiving CFC services. Through the use of risk management agreements, a monitoring plan is developed with the individual to review services and supports. Individuals receiving CFC services are informed of their right to request a review of their PCSP to ensure that their health and safety needs are being met through their self-directed service plan.

Abuse investigation services, as described above, are also a means of monitoring the health and welfare of CFC individuals.

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The Quality Assurance Team reviews are a source of administrative review of the health and welfare of individuals. The QA Team reviews, as described above, result in corrective action plans both for individuals and on a system-wide basis.

The methods for assuring that individuals are given a choice between institutional and community-based services

DHS assures that individuals who are eligible for services under CFC will be informed of feasible alternatives for community-based services and given a choice as to which type of service to receive. When an individual is determined to require the level of care provided in an institution, the individual or his or her representative will be:

1) Informed of any feasible alternatives available under CFC or the applicable HCBS Waiver, and

2) Given the choice of either institutional or home and community-based services. The choice of institutional or home and community-based services is documented on each eligible individual's record. Person-centered plan coordinators are responsible for collecting the appropriate Freedom of Choice documentation.

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Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of services provided under the Community First Choice Option. **The agency's fee schedule is effective for services provided on and after July 1, 2016**. Rates are published at: http://www.oregon.gov/dhs/spd/pages/provtools/index.aspx and Personal Support Workers rate are published at http://www.dhs.state.or.us/spd/tools/dd/cm/In-Home-Expenditure-Guidelines.pdf

The following 1915(k) provider types are reimbursed in the manner described:
Assisted Living Facility- Assisted Living Facility rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Assisted Living Facilities rates are paid based on the individual's assessed needs. The individual's needs result in a reimbursement in one of 5 payment levels. The different payment levels reflect the individual's acuity and ADL needs as follows:

Level 1 -- All individuals qualify for Level 1 or greater.

Level 2 -- Individual requires assistance in cognition/behavior AND elimination or mobility or eating.

Level 3 -- Individual requires assistance in four to six activities of daily living OR requires assistance in elimination, eating and cognition/behavior.

Level 4 -- Individual is full assist in one or two activities of daily living OR requires assistance in four to six activities of daily living plus assistance in cognition/behavior.

Level 5 -- Individual is full assist in three to six activities of daily living OR full assist in cognition/behavior AND one or two other activities of daily living.

Behavioral Support Consultants- DHS developed rates for Behavioral Coaches and Behavioral Consultants based on the usual and customary charges for similar services provided within Oregon.
Community Transition Providers- Payments are based on lowest market rate as evidenced by at least three bids.

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Home Accessibility Adaptations Providers- A scope of work is created for the adaptation. From the scope of work, bids or estimates of the cost of the adaptation are received from multiple qualified providers. The provider who submits the most cost-effective bid or estimate is chosen to complete the home adaptation.

Home Delivered Meal Providers- Home Delivered Meal rates are established utilizing detailed cost reports. The Department conducts an analysis of the cost reports. A weighted average is used to determine a statewide reimbursement rate.

Homecare and Personal Support Workers- Reimbursement rates for Home Care Workers and Personal Support Workers that provide In-Home services are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at 2-year intervals. Mileage reimbursement is collectively bargained, as well.

Community Transportation Providers- Contract rates for transportation brokerages are individually negotiated with the provider. The rates are based on a cost allocation model supplied by each transportation brokerage.

APD Adult Foster Care- Medicaid reimbursement rates for APD Adult Foster Home providers are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at two year intervals. The collective bargaining process is a public process.

Adult Foster Homes are paid a base rate with add-ons for specific medical, behavioral and ADL needs. The reimbursement rate may include the base rate with up to three add-on payments. Add-ons are paid if:

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(A) The individual is full assist in mobility or eating or elimination;
(B) The individual demonstrates behaviors that pose a risk to the individual or to others and the provider must consistently intervene to supervise or redirect; or
(C) The individual's medical treatments, as selected and documented on the SPD CA/PS, require daily observation and monitoring with oversight by a licensed healthcare professional, no less than quarterly, and the facility has trained staff to provide such service and does provide the service.

DD Children's Foster Care- A functional needs assessment is used to measure the support needs of an individual and determine rates for Adult FC and CDDFC based on those assessed needs.

Based on the answer selection, the functional needs assessment will then calculate a rate for the individual commensurate with the level of identified need. The rates from the various support needs area categories are then totaled to get an overall FC service rate. The rate structure is designed to fall within rate ranges based on groupings of level of need. There is a process for specific rate increases by exception if there is an identified need that is outside the standard assessment parameters, such as 2:1 support for a specific support task.

DD Children's Host Home- Each individual's support needs are assessed using a functional needs assessment. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual LOC redeterminations, annual ISP meetings, and when changes are brought to the person-centered plan coordinator's attention, an individual's provider of service, family member, friend or member of the community. The rate setting methodology incorporates other payroll expenditures (OPE), allowable administration percentages, and other costs associated with operating this service.

DD Adult Foster Care- The functional needs assessment is used to measure the support needs of an individual and determine rates for Adult FC and CDDFC based on those assessed needs.

Based on the answer selection, the functional needs assessment will then calculate a rate for the individual commensurate with the level of identified need. The rates from the various support needs area categories are then totaled to get an overall FC service rate. The rate structure is designed to fall within rate ranges based on groupings of level of need. There is a process for specific rate increases by exception if there is an identified need that is outside the standard assessment parameters, such as 2:1 support for a specific support task.

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Medicaid reimbursement rates for Adult Foster Care providers are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at two year intervals. The collective bargaining process is a public process.

Contracted Group Care Homes for Adults- Each individual's support needs be assessed using a functional needs assessment annually, when an individual requests it or when the individual's needs change. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual Level of Care (LOC) redeterminations, annual PCSP meetings, and when changes are brought to the person centered plan coordinator's attention, an individual's provider of service, family member, friend or member of the community.

- The functional needs assessment collects information about the person's support needs . This information is used to match the individual with one of several levels of expected support need.
- A funding tier is assigned. Each funding tier corresponds to one of the functional needs assessment derived expected support levels.
- Each funding tier contains several rates that reflect appropriate funding for a person with that particular level of support need, adjusted by the size of setting (licensed capacity) in which they reside.

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State Operated Group Care Homes for Adults- Each individual's support needs are assessed using a functional needs assessment. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual LOC redeterminations, annual POC meetings, and when changes are brought to the person centered plan coordinator's attention, an individual's provider of service, family member, friend or member of the community. The rate setting methodology incorporates 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 DHS can assure that the total funding does not exceed the cost of operating the site.

Group Care Homes for Children- Each individual's support needs are assessed using a functional needs assessment annually, when an individual request it or when the individual's needs change. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual Level of Care (LOC) redeterminations, annual PCSP meetings, and when changes are brought to the person centered plan coordinator's attention, an individual's provider of service, family member, friend, or member of the community.

• The functional needs assessment collects information about the person's support needs. This information is used to match the individual with one of several levels of expected support need.

• A funding tier is assigned. Each funding tier corresponds to one of the support levels as determined by the functional needs assessment.

• Each funding tier contains several rates that reflect appropriate funding for a person with that particular level of support need, adjusted by the size of setting (licensed capacity) in which they reside.

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The rate setting budget tool incorporates OPE, allowable administration percentages, and other costs associated with operating a business. The tool incorporates information on revenue and expenses about the service site, so that DHS can assure that the resulting budget reflects ONLY the supports for the specific individual and that the total site funding does not exceed the cost of operating the site.

Residential Care Facility Regular- Residential Care Facility (Regular) rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Residential Care Facilities are paid a base rate with add-ons for specific medical, behavioral and ADL needs. The reimbursement rate may include the base rate with up to three add-on payments. Add-ons are paid if

The individual is full assist in mobility or eating or elimination;

(B) The individual demonstrates behaviors that pose a risk to the individual or to others and the provider must consistently intervene to supervise or redirect; or

(C) The individual's medical treatments, as selected and documented on the SPD CA/PS, require daily observation and monitoring with oversight by a licensed healthcare professional, no less than quarterly, and the facility has trained staff to provide such service and does provide the service.

Residential Care Facility Contract- Residential Care Facility (Contract) rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Contracted rates are established for providers targeting a specific population and negotiating a specific rate for services provided to any individual within that target population. There are two types of contracted rates:
Supplemented Program Contract: A supplemented program contract pays a rate in excess of the published rate schedule to providers in return for additional services delivered to target populations.
Specific Needs Setting Contract: A specific needs setting contract pays a rate in excess of the published rate schedule to providers who care for a group of clients all of whose service needs exceed the service needs encompassed in the base payment and all add-ons. The provider must show the additional costs associated with providing care to the target population.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Community First Choice State Plan Option

Contracted rates are approved centrally. The provider submits a proposal for a contracted rate. A committee at DHS Central Office consisting of both program staff/management and rate staff/management review the proposal and determine if the provider meets the criteria. Contracted rates are renegotiated at contract renewal, usually at 1-2 year intervals.

Specialized Living Services Provider- Contract rates for specialized living providers are individually negotiated with the provider.

Long-term Care Community Nursing Services Registered Nurses- LTCCNS Registered Nurses are paid an hourly rate based on the current Department Published Rate Schedule. Rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. The LTCCNS RN will request prior-authorization and submit claims for client services utilizing billing codes per instructions in the LTCCNS RN Service Policy and Procedure Manual.

Emergency Response Providers- Rates are established using usual and customary local market rates.

Adult Day Providers- Rates are established using usual and customary local market rates.

Supported Living (SL) Agency Providers- The SL rate is individualized and based on the agency support and level of staffing required to meet the individual's assessed support needs as determined in the service plan. The SL budget is completed on the DHS mandated budget tool using DHS established rates for direct care staff and administrative costs.

Habilitation Agency Providers- The Habilitation budget tool is individualized and based on what level of staff and agency supports are required to meet specific individual service needs. The budget tool is completed on DHS mandated formats, and uses DHS established rates for direct care staff and administrative costs.

Exceptional Rate Payments- Exceptional rate payments may be made for services provided in Adult Foster Homes, Residential Care Facilities, and In-Home Services recipients. The services provided under an exceptional rate are for direct services provided to an individual. These are exceptional payments made to providers for services, documented in the PCSP that require additional levels of skill, additional staffing or more hours to provide care on the part of the provider.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Community First Choice State Plan Option

The provider's skill level relates to the provider's ability to provide services to an individual with complex medical or behavioral needs. The provider may need to hire additional staff with additional knowledge or abilities consistent with the needs of the individual specifically to provide care to that individual. Additional staffing may be the result of an individual who needs two-person transfers or an individual with unscheduled nighttime needs that precludes the primary provider from being able to sleep for more than 4 hours in a night.

Individuals needing ventilator care may require multiple providers that have fairly extensive knowledge of the provision of ventilator care. The payments are requested at a rate above the scheduled rate for the individual's assessed need.

Rates paid to community-based facility providers are an all-inclusive rate intended to cover the individual's needs identified in the person-centered service plan. Rates do not include the costs for room and board.

Rates paid to providers of in-home services include an hourly rate and may include the taxes and benefits associated with the compensation of Home Care and Personal Support Workers. Home Care Workers, Personal Support Workers may receive exceptional or enhanced rates based on the needs of the consumer and/or special training or certification of the provider.

Exceptional payments for services provided by in-home providers are made for the provision of in-home services, documented in the PCSP, that exceed the maximum number of hours of service under rule. Based on the defined needs of the individual. All exceptional rate payments are pre-approved centrally OAR 411-027-0000 and 0050 document the services and requirements to document the need for exceptional rate payments to providers. Payment rates are the same as those for in-home services described above.

Rate variances for services received by individuals are based on a documented need in the PCSP that requires additional support or staffing that cannot be met using the standard rate ranges. Providers must demonstrate the ability to meet the individual's support needs using the additional funds provided.

Payments made for State plan services under 1915(k) authority do not duplicate payments made for similar services under 1915(c), 1915(i), 1915(j), or 1115 authorities.

COVID-19 Disaster Relief Amendments

Temporarily effective until the end of the public Health Emergency

TN 20-0008
TN 20-0015

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Temporary changes to the Community First Choice State Plan Option

The State Medicaid agency seeks to implement the policies and procedures for the provision of Community First Choice State Plan Option**,** which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof) for the period of the public health emergency. These policies and procedures are time limited to no later than the termination of the national public health emergency, including any extensions.

The following are temporary measures related to Oregon's response to the COVID-19 outbreak. The state will work with CMS to revert back to pre-emergency policies as circumstances allow. Oregon requests an effective date of March 1, 2020 with a termination date to be determined by the end of the emergency declaration, including any potential extensions.

I: Eligibility

The following requirement is temporarily waived, as directed by DHS.

- Allow level of care evaluations or re-evaluations to be completed by communication methods in lieu of face to face, such as telehealth, as directed by DHS. Suspend the requirement for annual re-evaluations until the Emergency Declaration is repealed by the President unless there is a change of condition requiring additional services for the individual.

IV. Service Package:

- The following is added to the definition of Attendant Care Services:

  The state may determine when it is appropriate for attendant care services to be delivered By communication methods in lieu of face to face, such as telehealth for ODDS-eligible individuals.

- Allow two meals per day to be provided through the home delivered meals program.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Temporary changes to the Community First Choice State Plan Option

V. Qualification of Providers of CFC Services

The following sections are added:

- Homecare Workers and Personal Support Workers (Independent Providers): Homecare Workers and Personal Support Workers may be permitted to begin working unsupervised when a positive preliminary fitness determination (verified that they are not on the federal exclusionary list) is made, prior to a final fitness determination, as directed by DHS.

- DHS licensed and certified providers of 1915(k) services, as directed by DHS, may implement the following workforce shortage mitigation strategy:
  Staff providing attendant care for these providers may be permitted to begin working unsupervised when a positive preliminary fitness determination is made (verified that they are not on the federal exclusionary list), prior to a final fitness determination. Unless exempt under state law, staff must complete continuing education credits every 12 months, but may continue providing services if continuing education requirements are not completed, as directed by DHS.

VI: Home and Community-Based Settings

- Temporarily revise state plan provisions to allow the provision of Community First Choice Personal Care services to a recipient in an acute care hospital as long as the services are identified in an individual's personal plan of care, address needs that are not met through the provision of hospital services, are not duplicative of services the hospital is obligated to provide, and are designed to ensure smooth transitions between acute care settings and home and community-based settings, and preserve the individual's functional abilities.

IX: Assessment and Service Plan:

- Case Managers and Assessors may complete all assessments, including the risk assessment, by communication methods such as telehealth, in lieu of face to face assessments.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Temporary changes to the Community First Choice State Plan Option

X. Person-Centered Service Plan Development Process

- Case Managers may complete the person-centered service planning process by communication methods such as telehealth, in lieu of face to face.

- Person-centered service plans/revisions may be approved with a retroactive approval date for service needs identified to mitigate harm or risk directly related to COVID-19 impacts.

Section 7 – General Provisions
7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X___ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X___ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. ___X__ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __X___ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Oregon Medicaid state plan, as described below:

Please describe the modifications to the timeline. Oregon, has an approved 1135 waiver which allows modified Tribal consultation timelines. A DTLL will provide notification and consultation will continue after submission of this SPA.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

    a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

    Income standard: _____

    -or-

    b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

    Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

    Less restrictive income methodologies:

    Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. ____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. _____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

1. _____ Newly added benefits described in Section D are paid using the following methodology:

    a. _____ Published fee schedules –

    Effective date (enter date of change): _____

    Location (list published location): _____

    b. _____ Other:

Describe methodology here.

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

    a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

    b. Payments are increased through:

        i. _____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. _____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. _____ Are not otherwise paid under the Medicaid state plan;

   b. _____ Differ from payments for the same services when provided face to face;

   c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

   d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

4. __X___ Other payment changes:

Please describe. All policies and procedures describe in this SPA are time limited to no later than the termination of the national public health emergency, including any extensions.

The ability to make retainer payments for 3 episodes of 30 days to the following 1915(k) providers for the provision of attendant care services: Agency-operated attendant care pr0viders and Adult Day Services providers, to maintain capacity during the public health emergency (PHE).

The ability to make retainer payments for 3 episodes of 30 days to the following 1915(k) providers for the acquisition, maintenance and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living and health related tasks: Positive Behavioral Support Services providers, to maintain capacity during the public PHE.

a. Retainer payments may be provided in circumstances in which facility closures are necessary due to COVID-19 containment efforts.
b. Retainer payments attributable to each individual may be provided in circumstances in which attendance and utilization for the services drops below 75% of the monthly average for a 3-month period specified by APD which is December 2019 – February 2020 and ODDS which is October – December 2019.
c. Retainer payments will not exceed the anticipated 75% of monthly average of total billing and will be attributable to individuals and not paid to agencies as a lump sum.

*For ODDS –
Total billing means billing by person, by service. We look at the average of an individual service provided by each provider agency for an individual for October – December 2019. Then - we will pay up to 75% if the month's billing is less than 75% of the October – December 2019 average. This process will occur by person and by service.

For APD -
Total billing means APD agreed to reimburse Adult Day Service Programs 75% of their average total monthly revenue (from December 2019-February 2020) for a three-month period running from mid-March through mid-June. Total average revenue may be from any source other than Oregon's Developmental Disabilities program.

OHA/DHS will require an attestation from the provider:
a. Acknowledging that retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services occurred as identified in a state or federal audit or any other authorized third-party review;
b. That they will not lay off staff, and will maintain wages at existing levels;
c. That they had not received funding from any other sources, including but not limited to unemployment benefits and Small Business Administration loans, that would exceed their revenue for the last full quarter prior to the PHE, or that the retainer payments at the level provided by the state would not result in their revenue exceeding that of the quarter prior to PHE.

If a provider has not already received revenues in excess of the pre-PHE level but receipt of the retainer payment in addition to those prior sources of funding results in the provider exceeding the pre-PHE level, any retainer payment amounts in excess will be recouped.

If a provider had already received revenues in excess of the pre-PHE level, retainer payments are not available.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. _____ The individual's total income

    b. _____ 300 percent of the SSI federal benefit rate

    c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

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 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. 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. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.