

Application for

Section 1915(b) (4) Waiver

Fee-for-Service

Selective Contracting Program

February 12, 2018

v1.0

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**Application for Section 1915(b) (4) Waiver
Fee-for-Service (FFS) Selective Contracting Program**

Facesheet

The **State** of **Oregon** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is **APD Case Management Freedom of Choice Waiver.**
(List each program name if the waiver authorizes more than one program.)

Type of request. This is:

- an initial request for new waiver. All sections are filled.
- a request to amend an existing waiver, which modifies Section/Part _____
- a renewal request

Section A is:

- replaced in full
- carried over with no changes
- changes noted in **BOLD.**

Section B is:

- replaced in full
- changes noted in **BOLD.**

Effective Dates: This waiver/renewal/amendment is requested for a period of 5 years beginning July 1, 2018 and ending June 30, 2023.

State Contact: The State contact person for this waiver is Mike McCormick and can be reached by telephone at (503) 945-6229, or fax at, or e-mail at Mike.R.McCormick@state.or.us. (List for each program)

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:

Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal (if additional space is needed, please supplement your answer with a Word attachment).

The Oregon Health Authority (OHA) has regular quarterly meetings with the nine federally recognized Tribes, Urban Indian Programs and Indian Health Service (IHS) representatives. The agendas are mainly driven by the Indian communities of Oregon, Urban Indian Programs and Indian Health Service (IHS) representatives and are constructed by requesting topics to be discussed at the meeting. The OHA may engage the tribal and urban program representatives outside of the meeting setting through correspondence in the event a policy change is needed more quickly than the next meeting will support. Each Tribe and Indian Organization selects its representative to the meetings based on whom the Tribe or Indian Organization feels is best to represent their needs.

The OHA discusses proposed State Plan Amendments, waiver proposals or amendments, demonstration project proposals or amendments, and rule-making that may have a direct impact on American Indians, Tribal entities, Urban Indian programs, or IHS. Additionally, items that impact eligibility, reduce payment rates, change payment methodologies, reduce covered services, or alter provider qualifications/requirements are discussed.

Process:

The normal process is to distribute documents describing a subject modification (30) days prior to any formal submission to the Centers for Medicare and Medicaid Services (CMS). These items then are discussed in a scheduled quarterly meeting. The materials are distributed through the Tribal Liaison to the nine federally recognized Tribes, Tribal Urban Indian programs and Indian Health Service (IHS) representatives.

The OHA may also utilize an expedited process in the event a deadline is outside the control of the State, or in severely time limited situations. The expedited process includes at a minimum, 10 days in advance of the change, the State provides written notification with the proposed change; anticipated impact; method for providing comments/questions; timeframe for feedback; and an opportunity for a face-to-face meeting or conference call if requested.

Oregon submitted the notice as outlined in the expedited process on February 26, 2018, prior to our submission of this application. Oregon will be working with the tribes regarding any concerns they have throughout the approval process. The State does not feel the proposed change will have a negative impact on the Tribes, nor on any tribal members. The public notice and comment period ended March 30, 2018.

Program Description:

Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver (if additional space is needed, please supplement your answer with a Word attachment).

Through selective contracting, Oregon will be able to provide Case Management services as a 1915 (c) Waivered service through the existing service delivery model for Aged and Physically Disabled individuals. These services will be authorized through the Oregon APD 1915 (c) Waiver and delivered through the local Area Agencies on Aging (AAAs), and when not available in a service area, the Department of Human Services, Aged & Physically Disabled (APD) offices. Case Management services offered under the waiver will ensure the special income group requiring a waivered service maintain eligibility, while receiving home and community based care services under the 1915 (k) Option. The AAAs and APD offices provide Medicaid eligibility, as well as Case Management. The use of AAAs to provide eligibility and case management services has been part of Oregon's Medicaid delivery system since 1981, when legislation was passed in an effort to provide services to individuals with as few barriers as possible. In Oregon, this meant combining the eligibility and case management of Medicaid services with Older Americans Act services whenever possible. The use of exclusive contracting will make uniform case management services possible across the state and accessible to all individuals eligible for services. Waiver Case Management is services furnished to assist individuals in gaining access to needed medical, social, educational and other services. Waiver Case Management includes the following assistance:

- Assessment and periodic reassessment of individual needs. These annual assessment (more frequent with significant change in condition) activities include:
 - Taking client history;
 - Evaluation of the extent and nature of recipient's needs (medical, social, educational, and other services) and completing related documentation;
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

- Development (and periodic revision) of a specific care plan that:
 - is based on the information collected through the assessment;
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities: To help an eligible individual obtain needed services including activities that help link and individual with:
 - Medical, social, educational providers; or

- Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan such as making referrals to providers for needed services, and scheduling appointments for the individual.
- Monitoring and follow-up activities: Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. The activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

Waiver case management may include contact with non-eligible individuals, that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Providers maintain case records that document for all individuals receiving case management as follows:

- i. The name of the individual;
- ii. The dates of the case management services;
- iii. The name of the provider agency (if relevant) and the person providing the case management service;
- iv. The nature and content of the case management services received and whether goals specified in the care plan have been achieved;
- v. Whether the individual has declined services in the care plan;
- vi. The need for, and occurrences of, coordination with other case managers;
- vii. A timeline for obtaining needed services;
- viii. A timeline for reevaluation of the plan.

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM 4302.F)).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

By utilizing the current provider network, Oregon is assuring that clients' case management services are coordinated and seamless with other services offered under the various Medicaid authorities.

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver (if additional space is needed, please supplement your answer with a Word attachment).

The State will not be offering any State Plan Services through this selective contracting waiver. Oregon will be combining a 1915 (c) Waiver with this 1915 (b) Waiver to provide Case Management as a selective contracting service.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

1915(b) (4) - FFS Selective Contracting program

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

- a. **Section 1902(a) (1) - Statewideness**
- b. **Section 1902(a) (10) (B) - Comparability of Services**
- c. **Section 1902(a) (23) - Freedom of Choice**
- d. **Other Sections of 1902 – (please specify)**

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

the same as stipulated in the State Plan

is different than stipulated in the State Plan (please describe)

Oregon will be using a rate methodology that differs from the approved state plan. Oregon will be using a monthly rate methodology.

The interim monthly rate is established biennially based on the results of a workload study and model that averages the monthly cost per individual served using the average annual time for case management services per individual enrolled in the waiver and the cost to provide those services. The model uses the cost of case managers as the sum of the case manager's compensation expense, direct supervisory compensation expense, direct supportive activities and indirect administrative cost of the provider organization related to case management activities. The total cost of case management is divided by the number of waiver enrollees and divided, again, by 24 to arrive at the interim monthly rate.

Payment of the full monthly rate will be paid retrospectively for each individual enrolled in the waiver during that month upon receipt of a claim for a qualifying activity. Payment is not guaranteed. Providers will be responsible for providing as much case management services as each person enrolled needs within a month, irrespective of the cost of providing those services.

Case management rates will be established at the beginning of each state biennium period using this same methodology. Adjustments may be made to the rate periodically during the biennium if it is determined that the established rate is materially different than the cost of providing services.

On a biennial basis, State of Oregon revenue will be reconciled to actual cost with adjustments made to either increase the State's claim to cost or refund any revenue above cost.

On a biennial basis, payments to AAAs will be reviewed against the cost of providing services to ensure actual costs incurred do not exceed revenues. Excess payments, if any, will be recovered from AAA providers and claiming to CMS will be decreased.

2. **Procurement.** The State will select the contractor in the following manner:

- Competitive procurement
- Open cooperative procurement
- Sole source procurement

- Other (please describe)

Oregon will be contracting with AAAs to provide Case Management Services. When no AAA is available to contract with, the Oregon Department of Human Services will provide the services. This is consistent with the Oregon's long-standing history and legislative intent surrounding services offered through the AAAs. In 1981 Oregon legislative session passed statute which established the system requiring Medicaid services for individuals aged 60 and older to be delivered through AAAs. This service delivery model was later modified to include people with physical disabilities. AAAs have the right of refusal. When that occurs, the Oregon Department of Human Services conducts the eligibility and case management activities.

C. Restriction of Freedom of Choice

1. **Provider Limitations.**

- Beneficiaries will be limited to a single provider in their service area.

- Beneficiaries will be given a choice of providers in their service area.

(NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

Oregon will implement this new waiver service state-wide.

2. State Standards.

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents (if additional space is needed, please supplement your answer with a Word attachment).

There will be no change to the state standards detailed in the previously approved APD Waiver (0185). All providers must meet, accept and comply with the State's standards for reimbursement, quality and utilization. Case Management is a service that assists participants in gaining access to needed waiver and state plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services. The provider shall not have a personal financial interest in the services provided to the participant. Duplicate payments will not be made for case management services to the same participant by more than one provider. Case managers shall initiate and oversee the process of assessment and reassessment of the participant's level of care. Local offices are responsible for ongoing monitoring of the provision of services included in the participant's person-centered plan. Case managers must have a minimum of three face-to-face contacts with the participant per year. The participant's annual reevaluation may be counted as one face-to-face contact. Case managers must understand, respect and maintain confidentiality in regard to all details of their work.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations.** The following populations are included in the waiver:
 - Section 1931 Children and Related Populations
 - Section 1931 Adults and Related Populations
 - Blind/Disabled Adults and Related Populations
 - Blind/Disabled Children and Related Populations
 - Aged and Related Populations
 - Foster Care Children
 - Title XXI CHIP Children

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:
 - Dual Eligibles
 - Poverty Level Pregnant Women
 - Individuals with other insurance
 - Individuals residing in a nursing facility or ICF/MR
 - Individuals enrolled in a managed care program
 - Individuals participating in a HCBS Waiver program
 - American Indians/Alaskan Natives
 - Special Needs Children (State Defined). Please provide this definition.
 - Children will not be served through this waiver.
 - Individuals receiving retroactive eligibility

Other (Please define): [Click here to enter text.](#)

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.*, what constitutes timely access to the service?

Oregon Administrative Rules require that initial assessments and service plans are made within 45 days of the service request. The AAA contracts require that each individual who has been hospitalized receive a face-to-face assessment during the hospital stay, whenever possible. If not possible the assessment must be completed within 7 days of discharge.

Reassessments are required annually in both OAR 411-030-0050 and per 1915(c) waiver requirements. Oregon will require, contractually and in administrative rule that in-person contact be made at least quarterly, with monitoring conducted at least monthly. The Department standard to reply to an inquiry from an individual or their representative is 1 business day.

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment)?
2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion (if additional space is needed, please supplement your answer with a Word attachment).

If it is found, during the QA review that a service area provider has not been delivering timely services, a corrective action plan must be completed. The local office must submit a plan of correction to APD within 30 days of receipt of the QA report. APD then issues a final report to the local office. A detailed description of remediation activities and timelines is included in Part III.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

Oregon has invested significant efforts in developing work-load models with-in the APD/AAA service delivery system to ensure adequate staffing is available to serve all individuals needing services. Waiver eligible individuals have access to case management

services through 16 Area Agencies on Aging (AAA) and 33 Department of Human Services, APD offices providing case management services. AAAs and APD offices are required to ensure adequate capacity for case management services within their contract.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

Time studies have been conducted to determine the number of case managers needed across the state to ensure that all waiver eligible individuals can receive adequate and timely access to case management services. This work-load model is quite easily adaptable to adjust to service needs growth. The time study was conducted categorizing the needed level of case management services based on whether an individual lives in their own home or individuals living in community based care settings.

The current analysis shows individuals living in their own homes require 31.72 hours of case management service per year on average while individuals living in a community-based care setting require 24.61 hours of case management service on average per year. The difference in the amount of case management used demonstrates Oregon's extensive effort to assist individuals to live in the least restrictive setting possible. Based on the current the time studies, the APD/AAA system currently requires 684.3 FTE for case managers to serve waiver eligible individuals. These models, adjusted for the 2019-2021 biennium require 713.28 FTE for case managers. Allocation of case managers is conducted using local area waiver enrollee demographics.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program (if additional space is needed, please supplement your answer with a Word attachment).

Monthly utilization reports ensure adequate capacity in all geographic areas of the state. Allocation of case management funding and staffing is conducted using local area waiver enrollee demographics. The concurrently operating 1915(c) APD waiver (#0185) allows for the enrollment of all eligible persons with no wait list. Provider capacity is assured as a requirement for the 1915(c) waiver. Local area management ensures any single office or case manager is not over capacity. The local area management will also adjust staffing for categories of individuals with heavy case management needs. Because of the variabilities that can occur from month to month, trending of this data is commonly used.

Capacity is also reviewed through the Office of Program Integrity, Waiver QA Team reviews of waiver performance measures. These reviews include desk reviews, electronic file reviews and face-to-face contact with waiver participants to determine that services are being provided timely, in accordance with State and waiver requirements, and as agreed with the service recipient. Case management notes detail the services provided to participants. Documents such as the service plan and the CA/PS assessment are readily available in the electronic file. The Waiver QA Team reviews the service plan and assessment, monthly

monitoring and risk monitoring to determine if the plan meets the needs of the participant. The electronic file documents when services were provided and that case management claims are appropriately documented. Follow-up face-to-face interviews with participants also provides verification of service provision.

Remediation activities and timelines for remediation of any measures that fall below acceptable standards are described in Part III.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

Due to the variability of case management needs from month-to-month, utilization standards will be reviewed on an annual basis. Each individual receiving services should have no fewer than one service assessment and service plan conducted per year. Dependent on an individual's unique needs, risk monitoring will be conducted annually at a minimum, and as frequently as monthly. Complete service plan reviews will be conducted no fewer than three times per year, per enrollee.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above (if additional space is needed, please supplement your answer with a Word attachment)?

The QA Team conducts utilization reviews using the 1915(c) waiver performance measures. These reviews include desk reviews, electronic file reviews and face-to-face contact with waiver participants to determine that services are being provided timely, in accordance with State and waiver requirements, and as agreed with the service recipient. Case management notes detail the services provided to participants. Documents such as the service plan and the CA/PS assessment are readily available in the electronic file. The QA Team reviews the service plan and assessment, monthly monitoring and risk monitoring to determine if the plan meets the needs of the participant. The electronic file documents when services were provided and that case management claims are appropriately documented. Follow-up face-to-face interviews with participants also provides verification of service provision.

Remediation activities for any measures that fall below acceptable standards are described in Part III.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above (if additional space is needed, please supplement your answer with a Word attachment).

Local office management review monthly reports of individuals not receiving case management services to ensure appropriate utilization. If an individual is not receiving the expected level of service, the case manager will make contact with that individual by telephone, a face-to-face visit, or contact with the individual's family or service provider. Additional system-wide remediation activities and timelines for remediation are described in Part III.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

Since this §1915(b)(4) waiver operates concurrently with a §1915(c) waiver, evidence of monitoring is submitted as part of the annual CMS-372 report; specifically as documentation of the CMS-approved performance measures. The waiver evidence package submitted prior to renewal of the 1915(c) waiver ensures CMS approval of the discovery and remediation activities conducted during the waiver period.

ii Take(s) corrective action if there is a failure to comply.

The process for monitoring, including corrective action, is described in #2 below.

2. Describe the State's contract monitoring process specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

The Oregon Health Authority and Department of Human Services utilize performance measures to evaluate the 1815(c) Aging and People with Disabilities waiver (0185) as well as the 1915(k) Community-First Choice option and 1915(b)(4) waiver. These monitoring activities are reviewed annually by CMS through the submission of the CMS-372 reports and the submission to CMS of an evidence package one time during the waiver cycle. The CMS review and final report of the evidence package affirms that all performance measures are met or that a corrective action plan is required.

The Quality Improvement Strategy utilizes discovery, analysis and remediation activities as the method of ensuring that Home and Community-Based Services provided through the waivers and state plan are monitored and that necessary corrective action processes are in place.

The discovery and analysis phase will occur on a two-year cycle for all Home and Community-Based services authorized under Section 1915(b), (c) and 1915(k) authorities.

Case reviews are conducted by the DHS Office of Program Integrity, Waiver QA Team. The Waiver QA Team operates independently of both OHA, the Medicaid Agency and Aging and People with Disabilities, the operating agency, although reports to the umbrella agency (DHS). The Waiver QA Team reviews include desk reviews, electronic file reviews and face-to-face contact with waiver participants to determine that services are being provided timely, in accordance with State and waiver requirements, and as agreed with the service recipient. Case management notes detail the services provided to participants. Documents such as the service plan and the CA/PS assessment are readily available in the electronic file. The Waiver QA Team reviews the service plan and assessment, monthly monitoring and risk monitoring to determine if the plan meets the needs of the participant. The electronic file documents when services were provided and that case management claims are appropriately documented. Follow-up face-to-face interviews with participants also provides verification of service provision.

Remediation is an ongoing process that will occur during the discovery phase. Individual remediation will occur when corrective action is needed in any one geographic area or field office. System-wide remediation activities will occur every two years, when required, based on statewide discovery and analysis. Both individual and system-wide remediation activities will require a corrective action plan.

Data and reports gathered and created by Program Integrity staff during quality reviews and QA activities identified in the performance measures are reviewed and analyzed on a continuous, ongoing basis by the OHA liaison to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Review and remediation activities will be tracked in an electronic system accessible to appropriate DHS and OHA staff for the purpose of maintaining timelines, ensuring compliance, and to issue reports relating to review and remediation activities.

OHA and DHS will conduct quarterly meetings (Quality Assurance Review and Remediation Committee (QARRC)), to review and analyze aggregated reports and remediation efforts resulting from performance measure activities to identify trends, systemic issues and to prioritize and implement system improvements.

Meeting participants will include representatives from DHS, OHA, DHS/OHA Shared Services, community partners (AAAs), advocates, and stakeholders. DHS/OHA representation will include staff and management responsible for QA activities from Office of Developmental Disability Services, Aging and People with Disabilities, Office of Licensing and Regulatory Oversight, Office of Adult Abuse Prevention and Investigations, Child Welfare and Division of Medical Assistance Programs (Medicaid Agency).

Upon completion of OHA's analysis and review of DHS' quality assurance activity data and reports, and OHA's own review and remediation of DHS operations, all relevant information from both

agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and DHS.

The MOCSC annually reviews the reports, documents DHS and OHA remediation efforts, and offers feedback on trends and implementation of systemic quality improvement activities.

Additionally, the MOCSC meets at least quarterly to coordinate and review all mutual policy issues related to the operation and administration of the Medicaid/CHIP program including state plan amendments, waiver requests, rules, procedures, and interpretive guidance. A Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) for OHA and DHS meets at least twice per year to review Medicaid/CHIP related policy. The Steering Committee is comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of policy-related issues and delineation of responsibilities, including establishment of a strategic plan for the two agencies.

On an ongoing basis and during regularly scheduled meetings, DHS and OHA staff addresses individual and systemic issues and remediation efforts. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving DHS reports, documents, rules, policies and guidelines. OHA, on a continuous and ongoing basis, reviews and provides input to DHS' quality control processes for Medicaid/CHIP programs managed by the DHS to assure proper oversight of central office and field operations. This includes ongoing review and approval of DHS operational oversight and quality assurance activities.

As the OHA liaison, QARRC, and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Steering Committee outlined above, thus informing executive management of OHA and DHS.

- ii Take(s) corrective action if there is a failure to comply.

Individual remediation activities will require follow-up by the OHA and/or DHS Quality Management Staff to determine that the corrective action was successfully completed by the field office, licensing or abuse investigation unit. The results of any remediation will be submitted to an inter-departmental workgroup for discussion, data collection and reporting. When individual and/or system-wide remediation activities are warranted based on discovery and analysis, the following time frames will be used to ensure these items are remediated in a timely manner. Non-compliance will be determined by any performance measure that falls below 86% accuracy.

DHS timelines for remediation:

Corrective Action Plans: Within 45 days of Department's identification of need for plan of correction, entities reviewed must submit a plan of correction.

Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 45 days of Department's approval of entity's plan of correction.

Completion of corrective actions: Within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff)

Timelines for systemic remediation:

Required system-wide changes: If changes require revision of administrative rules, the required changes will be completed within the time frames required by the administrative rule process, including Rule Advisory Committees (including stakeholder input), Administrative rule hearings and statutory filing time frames.

If system-wide changes require waiver amendments, the process will be completed at the time of approval of the waiver amendment. This will include the 30 day public and tribal input period and 90 day approval process.

If system-wide changes require waiver amendments, the process will be completed at the time of approval of the waiver amendment. This will include the 30 day public and tribal input period and 90 day approval process.

Follow-up to determine effectiveness of remediation activities will occur during the next discovery and review cycle using a comparison of compliance level pre- and post-remediation to determine the level of success with the remediation activity. After initial remediation is completed a follow-up will occur within 180 days to determine the effectiveness of the method. If additional remediation is required, it will be added to the corrective action plan.

The Quality Improvement System will ensure that all discovery and remediation activities have a process in place to ensure system improvement. The Oregon Health Authority and Department of Human Services will collaborate through inter-departmental meetings to coordinate these activities. These meetings will occur at least quarterly to report on the corrective actions and follow-up required to ensure system improvement.

Remediation strategies include training, revision of administrative processes and procedures, administrative rule revisions and waiver amendments. These strategies will be used based on the results of the discovery and analysis of the related performance measure. If compliance with the performance measure falls below 86%, a request for a corrective action plan, including activities and time lines for completion and follow-up will be required. Follow-up will include a discovery process using a valid random sample. Follow up discovery will be conducted using the standardized survey instruments and methods utilized during the initial discovery phase.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

Oregon administers most of the health and human services for the aging and people with disabilities populations through its AAA contracts and local DHS offices. These services include:

- Medicaid eligibility
- Older Americans Act programs
- Supplemental Nutritional Assistance Program
- Adult Protective Services
- home-care worker approval
- community based care residential setting licensure
- §1915(c) waiver eligibility determinations, level of care evaluations, needs assessments, service planning, authorization of services and monitoring of service delivery and plans.

Oregon established this coordinated effort in the early 1980s. Restricting case management to the existing service delivery model utilizes the existing knowledge of local resources, geographic proximity of local case managers to the individuals receiving services, and the continuity of a single organization coordinating all services and responsible for all aspects of the administrative functions, which are often co-dependent with waiver case management services. Universally used computer systems in the existing service delivery model ensure that all staff are accessing the same information, without delays in data transfer. This is possible because of the limitation in providers of case management services to our existing state and AAA staff. Separating the functions between other provider types would add administrative cost and cause delays in service delivery for individuals receiving services. Selective contracting for these services increases the quality care to individuals receiving services.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

Waiver enrollees will receive information about the selective contracting program when they are screened for services and when they receive an assessment or reassessment for long-term care services.

B. Individuals with Special Needs

- The State has special processes in place for persons with special needs
(Please provide detail).

Individuals who are enrolled in this waiver program all have special needs. A person-centered plan is a requirement of case management services for all individuals receiving services under

this waiver and under the § 1915 (c) service that runs concurrent with this waiver. Each plan lists services that are needed to meet the individual's unique needs.

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State’s efficient and economic provision of covered care and services (if additional space is needed, please supplement your answer with a Word attachment).

By utilizing a single entity in a service area duplication is minimized and communication is streamlined. When one agency is responsible for all aspects of case management for multiple programs information services are able to be consolidated, administrative services are able to be streamlined, and coordination of services is more efficient. By using the existing service delivery structure, the impact of changes is significantly reduced.

2. Project the waiver expenditures for the upcoming waiver period.

All amounts listed are using Total Fund Expenditure projections.

Year 1 from: 7/1/2018 to 6/30/2019

Trend rate from current expenditures (or historical figures): NA%

Projected pre-waiver cost	<u>NA</u>
Projected Waiver cost	<u>\$59,904,692</u>
Difference:	<u>NA</u>

Year 2 from: 7 / 1 / 2019 to 6 / 30 / 2020

Trend rate from current expenditures (or historical figures): NA %

Projected pre-waiver cost	<u>NA</u>
Projected Waiver cost	<u>\$62,300,879</u>
Difference:	<u>NA</u>

Year 3 (if applicable) from: 7 / 1 / 2020 to 6 / 30 / 2021

(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost	<u>NA</u>
Projected Waiver cost	<u>\$64,792,914</u>
Difference:	<u>NA</u>

Year 4 (if applicable) from: 7 / 1 / 2021 to 6 / 30 / 2022

(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost	<u>NA</u>
Projected Waiver cost	<u>\$67,384,631</u>
Difference:	<u>NA</u>

Year 5 (if applicable) from: 7 / 1 / 2022 to 6 / 30 / 2023

(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost	<u>NA</u>
Projected Waiver cost	<u>\$70,080,016</u>
Difference:	<u>NA</u>