

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Request Information

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

**B. Program Title:**

**Aged and Physically Disabled Waiver**

**C. Waiver Number: OR.0185**

**Original Base Waiver Number: OR.0185.**

**D. Amendment Number:**

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

04/01/19

**Approved Effective Date of Waiver being Amended: 01/01/17**

### 2. Purpose(s) of Amendment

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**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:

This amendment, together with an amendment to the concurrently running 1915(b)(4) selective contracting waiver (#OR11), will add Oregon Tribes as contracted case management entities. The participating tribes will provide Waiver Case Management services to tribal members throughout the State.

The amendment also removes Performance measures numbers 13, 16 and 25, which are not applicable to this waiver. These performance measures are in the areas of provider assurances and freedom of choice assurances. The providers in this waiver are not licensed or certified and have no training requirements prior to providing services nor are there ongoing training requirements. Case management providers are restricted under a 1915(b)(4) selective contracting waiver and transition services are payments for goods and services that are not delivered by direct service providers.

### 3. Nature of the Amendment

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**A. Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

| Component of the Approved Waiver                       | Subsection(s) |
|--|---------------|
| <input checked="" type="checkbox"/> Waiver Application | 1, 2, 6-I     |

| Component of the Approved Waiver  | Subsection(s)          |
|---|------------------------|
| <input checked="" type="checkbox"/> Appendix A – Waiver Administration and Operation                | A.6, Quality Improve   |
| <input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility                 | 6-i,                   |
| <input checked="" type="checkbox"/> Appendix C – Participant Services                               | C1/C3, C2-f, Quality   |
| <input checked="" type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery | D1-c,-d,-e,-f,-g, D2-ε |
| <input type="checkbox"/> Appendix E – Participant Direction of Services                             |                        |
| <input checked="" type="checkbox"/> Appendix F – Participant Rights                                 | F1                     |
| <input checked="" type="checkbox"/> Appendix G – Participant Safeguards                             | G1-c, G2-a,-b,-c, Qu   |
| <input checked="" type="checkbox"/> Appendix H  | H1-a                   |
| <input checked="" type="checkbox"/> Appendix I – Financial Accountability                           | I1-a, Quality Improv   |
| <input type="checkbox"/> Appendix J – Cost-Neutrality Demonstration                                 |                        |

**B. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)
- Modify Medicaid eligibility
- Add/delete services
- Revise service specifications
- Revise provider qualifications
- Increase/decrease number of participants
- Revise cost neutrality demonstration
- Add participant-direction of services
- Other

Specify:

Adds Oregon Tribes as providers of case management services. This waiver runs concurrently with 1915(b)(4) selective contracting waiver (OR110). Both waivers are being amended with an effective date of March 1, 2019.

Removes Performance Measures that are not applicable to this waiver.

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

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

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

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

**Aged and Physically Disabled Waiver**

**C. Type of Request:** amendment

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

- 3 years  5 years

**Original Base Waiver Number:** OR.0185

**Draft ID:** OR.008.06.02

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

Regular Waiver

**E. Proposed Effective Date of Waiver being Amended:** 01/01/17

**Approved Effective Date of Waiver being Amended:** 01/01/17

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

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

**Hospital**

Select applicable level of care

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

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

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

**Nursing Facility**

Select applicable level of care

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

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

**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

## 1. Request Information (3 of 3)

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

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

**Waiver(s) authorized under §1915(b) of the Act.**

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

The waiver runs concurrently with an approved 1915(b)(4)(OR.11) waiver to restrict freedom of choice of case management providers to employees of Department of Human Services, Area Agency on Aging offices \*and Oregon Tribes\*.

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

**§1915(b)(1) (mandated enrollment to managed care)**

**§1915(b)(2) (central broker)**

**§1915(b)(3) (employ cost savings to furnish additional services)**

**§1915(b)(4) (selective contracting/limit number of providers)**

**A program operated under §1932(a) of the Act.**

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

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

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

Specify the program:

The Oregon Health Plan.

Effective July 1, 2013, Oregon implemented the 1915(k) Community First Choice Option that provides Home and Community-Based services authorized under section 1915(k) of the Act. State plan HCBS provides ADL/IADL and other health related tasks to individuals meeting level of care criteria in home and community-based settings.

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.

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

Check if applicable:

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

## 2. Brief Waiver Description

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

Oregon Health Authority (OHA) administers waiver OR.0185 to provide long-term support services for people who are aged (age 65 and above) or physically disabled (age 18 or above). The waiver is operated by the Department of Human Services.

Purpose:

The Oregon Department of Human Services (DHS) operates Waiver OR.0185 to promote a service environment that values and fosters individual independence, dignity, privacy, and choice. The waiver supports preferences of individuals who require nursing facility level of care for long-term support services at home or in community-based alternatives.

Goals and Objectives:

The Aging and Physically Disabled waiver is designed to enable individuals who require nursing facility level of care, to receive those services and supports in their home or in a community-based setting outside the home. This program provides services to enable independent living or assisted living in community-based settings.

Organizational Structure

OHA, Oregon's Single State Medicaid agency, is responsible for monitoring and oversight of the waiver. OHA exercises monitoring and oversight by reviewing and approving all submissions related to this waiver. OHA also provides monitoring and oversight of the Quality Improvement Strategy and Performance Measures. DHS, Oregon's operating agency, is responsible for the administration and oversight of waiver services throughout the state. DHS provides leadership, regulates services, provides protective services, manages resources, and carries out responsibilities related to Medicaid program participation in long-term support services.

Local case management entities are entry points for all services and perform standardized functions such as level of care assessment/reassessment, needs assessment, person-centered plan development, service authorization, service monitoring, and advising and ensuring informed choice between nursing facility and community-based care and qualified providers of community-based services. These local entities are either DHS field offices, Area Agencies on Aging (AAA's) \*or Oregon Tribes\* performing pursuant to OAR 411-002-0100 through 0175 and written agreements with DHS. These entities are the authorized service providers under the 1915(b)(4) APD Case Management waiver.

DHS contracts with qualified providers for the provision of waiver services. Case management providers are restricted to those that meet the qualifications and definitions as described in the authorized 1915(b)(4) APD Case Management waiver.

Service Delivery Methods

Case Management services are delivered through DHS field offices, Area Agencies on Aging (AAAs) \*and Oregon Tribes\*. The Oregon Health Authority (hereinafter referred to as OHA) is the Single State Medicaid/CHIP agency (SSMA) responsible for the administration of programs funded by Medicaid and CHIP in Oregon. The Department of Human Services is the Operating Agency responsible for the operation of certain programs under Medicaid, which includes home and community-based waivers.

OHA and DHS, by written inter-governmental agreement (IGA), have defined the working relationship between the two agencies and outlined the OHA delegation of authority to DHS for day-to-day operation of waiver programs.

An excerpt from the IGA:

3.0

"OHA and DHS recognize responsibilities of OHA as the single state Medicaid/CHIP agency which retains ultimate administrative authority and responsibility for the operation and oversight of the Medicaid/CHIP program. OHA must ensure that all funds expended under its authority are spent appropriately and in accordance with federal and state law, federal and state regulations, the State Plan, State Plan amendments and waivers. At the same time, both agencies recognize that, consistent with the general principles upon which this agreement is based, DHS, as the operating agency, conducts delegated administrative and operational activities and functions, and provides programmatic expertise for intrinsic elements of the Medicaid/CHIP program. OHA exercises administrative discretion in the administration or supervision of the Medicaid/CHIP program pursuant to 42 C.F.R. Sec. 431.10(e). OHA will provide oversight to DHS, as the operating agency, in conducting the administrative and operational functions identified in this agreement. OHA and DHS recognize responsibilities of OHA as the single state Medicaid/CHIP agency which retains ultimate administrative authority and responsibility for the operation and oversight of the Medicaid/CHIP program. OHA must ensure that all funds expended under its authority are spent appropriately and in accordance with federal and state law, federal and state regulations, the State Plan, State Plan amendments and waivers. At the same time, both agencies recognize that, consistent with the general principles upon which this agreement is based, DHS, as the operating agency, conducts delegated administrative and operational activities and functions, and provides programmatic expertise for intrinsic elements of the Medicaid/CHIP program. OHA exercises administrative discretion in the administration or supervision of the Medicaid/CHIP program pursuant to 42 C.F.R. Sec. 431.10(e). OHA will provide oversight to DHS, as the operating agency, in conducting the administrative and operational functions identified in this agreement."

### 3. Components of the Waiver Request

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

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

- Yes. This waiver provides participant direction opportunities. Appendix E is required.
  - No. This waiver does not provide participant direction opportunities. Appendix E is not required.
- F. **Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. **Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. **Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. **Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. **Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

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

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

- Not Applicable  
 No  
 Yes

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

- No  
 Yes

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

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

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

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

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

#### 5. Assurances

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

**A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

- As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
- Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
- Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

**B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:  
Public comment is solicited according to public notice requirements as described in 42 CFR 441.304(f)(1)-(4) and/or 42 CFR 447.205. For substantive changes to the waiver, the following process is used:  
1)Public comment is solicited by posting of a public notice and news release of DHS intent to amend or renew a waiver. The notice is posted electronically at: <https://www.oregon.gov/DHS/DHSNEWS/Pages/index.aspx>. Notices are also sent electronically to FlashAlert service. FlashAlert collects emergency messages and news releases from 1,760 organizations in the Portland/Salem/SW Washington area and provides it to the news media via a continuously updated website and e-mails. It automatically places this information into the websites of participating stations and newspapers. It sends our press releases to several hundred news media sites throughout Oregon. A physical copy of the notice will also be posted in each DHS/AAA field office. The contents of the public notice include a description of the proposed change, a request for public comment, the proposed effective date, and a copy of the proposed waiver application. It will also include instructions for obtaining a physical copy of the documents. The notice also includes the time period for submission of public comments and the contact information for submitting comments. A physical copy of the documents will be made available to the public for review in each DHS/AAA field office.  
After the comment period has ended, the comments are compiled, summarized and provided to Department management to determine if any changes are required based on input received. Any changes made to the proposed waiver application are made prior to submission to CMS. The submitted application is made available to the public after submission.  
2)Public input is solicited in a timeframe that provides the public sufficient time to comment and the Department

sufficient time to summarize and make any necessary changes prior to submission of any waiver application that proposes substantive changes. The public comment period provides the public 30 days to comment on substantive changes and ensures that the Department can summarize and make any needed changes to the waiver application prior to submission. The process is completed within 30 days prior to implementation of the proposed change or submission of the waiver application to CMS, whichever comes first.

3) This process is used for both existing waivers that have substantive changes proposed, either through the renewal or the amendment process, and new waivers.

4) Oregon Tribes are notified and provided adequate time to provide input in accordance with Presidential Executive Order 13175 and Oregon's Medicaid State Plan (Section 1.4 Tribal Consultation Policy). The Department 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 and urban Indian programs or IHS in the SB 770 quarterly meetings.

Impacts that are considered to have direct effects on Native Americans, Urban Indian programs or IHS are changes that would impact eligibility determinations, changes that reduce payment rates or changes in payment methodologies, reductions in covered services, changes in provider qualifications/requirements, and proposals for demonstrations or waivers.

Process:

\*Sixty (60)\* days prior to a State Plan submission to CMS, the Division distributes documents describing a proposed waiver amendment. This is normally discussed in a scheduled quarterly SB 770 meeting. Approximately ten (10) days prior to the quarterly 770 meeting the Division distributes the agenda and documents describing the proposed changes. This is distributed through the Tribal Liaison to the nine federally recognized Tribes, Tribal Urban Indian programs and Indian Health Service (IHS) representatives. The types of entities on the distribution list include, but are not limited to:

1) Oregon Tribal Governments (i.e. Tribal Executive Council, Tribal Business Council, etc.)

2) Tribal Chairman or Chief or their designated representative(s)

3) Tribal Health Clinic Executive Directors of Oregon's 638/FQHC providers

4) IHS representatives

5) Tribal Organizations established to represent IHS and Tribal health programs and such as the Northwest Portland Indian Health Board

6) Urban Indian program(s) Executive Director(s) or designee(s)

In instances where a waiver would need to be submitted prior to a regularly scheduled '770' meeting the Division would utilize electronic mail or schedule conference calls.

The Division may also utilize an expedited process in the event a deadline is outside the control of the Division, or in severely time limited situations. The expedited process includes at a minimum, 10 days in advance of the change the Division 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.

Tribal notification occurred on \*4-6-2017\* using email communication, as described above. A face-to-face meeting was held with the tribes on May 2 and the comment period was extended through 5-31-2017. The tribes had questions regarding the number and geographic location of tribal members that would lose services. APD responded that approximately 26 tribal members may lose services, but cannot be identified at an individual level.

Public notice period commenced on \*4-11-2017\* and was completed on \*5-11-2017\*. Public notice was posted in electronic format here: <http://www.oregon.gov/DHS/DHSNEWS/NewsReleases/apd-waiver-amendment-comments-4-2017.pdf> and to FlashAlert as described above. Public notice with a physical copy of the waiver application was posted in all local offices on the same day. No comments were received.

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

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

## 7. Contact Person(s)

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

**Last Name:**

Simnitt

**First Name:**

David

**Title:**

Interim Medicaid Director

**Agency:**

Oregon Health Authority

**Address:**

500 Summer St NE

**Address 2:**

**City:**

Salem

**State:**

Oregon

**Zip:**

97301-1079

**Phone:**

(503) 945-5636 **Ext:**   TTY

**Fax:**

(503) 945-5872

**E-mail:**

david.simnitt@dhsosha.state.or.us

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

**Last Name:**

Carson-Cottingham

**First Name:**

Ashley

**Title:**

Director, Aging and People with Disabilities

**Agency:**

Department of Human Services

**Address:**

500 Summer St. NE

**Address 2:**

**City:**

Salem

**State:** **Oregon**

**Zip:**

97301-1064

**Phone:**

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## 8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

**Signature:**

State Medicaid Director or Designee

**Submission Date:**

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:**

**Oregon**

**Zip:**

**Phone:**

Ext:   TTY

Fax:

E-mail:

**Attachments**

#### Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

Oregon is requesting to amend the Aging and Physically Disabled Waiver #0185 to:

- Address a change to Oregon Administrative Rule (OAR) that affects the nursing facility (NF) level of care (LOC) assessment; and
- Add Transition Services as an approved waiver service.

The OAR changes will result in a small reduction in number of waiver participants. The OAR revisions modify the tasks that comprise activities of daily living and adjust assistance levels that drive eligibility. Based on analysis of more than 1400 cases the Department estimates that the OAR changes will impact 4% of consumers who will no longer meet NF LOC criteria; in Oregon this equates to approximately 1,219 individuals.

Individuals who no longer meet the Level of Care will be provided an appropriate timely decision notice. Decision notices must be mailed at least 10 days prior to the action being taken, per Oregon Administrative Rule 461-175-0050. The notice will include the individual's right to a Medicaid fair hearing and information regarding continuation of benefits during the hearing process. Continuation of services after the notice and hearing period are not subject to Federal Financial Participation.

Case Managers will assist participants to transition into any non-Medicaid funded services for which they may be eligible. Individuals who lose waiver eligibility, but maintain Medicaid eligibility may access State Plan Personal Care services. Case managers will have tools available to help them transition individuals to in-home settings, including access to available low-income housing and community resources. Aging and Disability Resource Connection of Oregon will offer choice counseling and access to other community supports.

Individuals between 18 to 21 years of age will not be affected by the rule change. These individuals are assessed using the Medically Involved Children's (MICW) Level of Care assessment tool for NF LOC. The rule change for the adult Level of Care assessment does not affect the MICW assessment.

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

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

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

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

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

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

“The State assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.”“The State assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.”

The most recent version of the transition plan can be found at <http://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCBS/Pages/Transition-Plan.aspx>

Individuals enrolled in this waiver reside in their own or family homes or in licensed/certified settings of their choice.

#### Phase I. Initial Systemic Regulatory Assessment (June- 2014 – January 2016)

DHS and OHA have completed an initial assessment of Oregon Revised Statutes (ORS), Oregon Administrative Rules (OAR), policies and contracts to determine regulatory compliance with the new Code of Federal Regulations across three service delivery systems; OHA, Health Systems Division (HSD), Aging and People with Disabilities (APD), and Office of Developmental Disability Services (ODDS). In general, DHS's and OHA's initial assessment has led to the conclusion that ORSs, OARs, policies, and contracts are in compliance with the HCBS regulations. Areas that need to be addressed are identified below. However, key activities in the transition plan will further assess compliance and remediate any remaining areas of concern. The initial assessment of ORSs, OARs, policies, and contracts specific to provider-owned, controlled, or operated residential HCBS settings was completed on August 4, 2014. The three service delivery systems reviewed ORSs 409, 410, 413, 427, 430, and 443, OARs (see Appendix A), policies, and contracts. This assessment led to the creation of an "initial global scorecard". The scorecard (Appendix B) evaluates rules and regulations related to provider-owned, controlled, or operated settings licensed/certified by APD, HSD and by DHS's Office of Licensing and Regulatory Oversight (OLRO) on behalf of APD and ODDS programs. These setting types include Adult Foster Homes for all three service delivery systems, Assisted Living Facilities, Group Homes, Residential Care Facilities, Residential Treatment Facilities and Residential Treatment Homes. These programs are included in Oregon's Medicaid State Plan and Waiver Authority (see Appendix C). Upon release of CMS's guidance for non-residential settings, DHS and OHA completed the same initial regulatory assessment for certified and unlicensed settings, such as employment and adult day programs, providing HCBS to determine if the statutes, rules, policies and contracts for these settings are in compliance with the new regulations. The three service delivery systems reviewed pertinent ORSs, OARs (see Appendix A), policies, and contracts. The initial global scorecard was updated with the results of this initial regulatory assessment of non-residential settings. That initial assessment was completed on January 22, 2015.

The initial global scorecard was not intended to be the final determination of individual site compliance or identification of any necessary site specific changes, but it provides an initial snapshot of the regulatory status of Oregon's HCBS system during Phase I. Through the initial systemic assessment, DHS and OHA found that no immediate changes were necessary to its Oregon Revised Statutes (ORS). However, since submitting the initial Statewide Transition Plan on October 13, 2014, with the initial global scorecard, Oregon determined that changes were needed to OARs to remove any areas of ambiguity, better align with the HCBS regulations, and facilitate initial and ongoing provider compliance by establishing timelines for completion of activities in accordance with the Transition Plan. Through the initial systemic regulatory assessment of State statutes, rules, policies and contracts, DHS and OHA determined that all of Oregon's regulations, at that time, met the following components of the HCBS regulation:

- The setting is selected by the individual, or their representative, from among all available options, including non-disability specific settings, unless there are court-mandated restrictions that prohibit the individual from being served in a particular setting which would be articulated in the individual's person-centered service plan.

- The setting choice is identified and documented in the person-centered service plan and is based on the individual's needs and preferences.
- The service delivery system facilitates individual choice regarding services and supports, and who provides them.

At the same time, DHS and OHA determined that service-delivery system regulations for most residential setting types met the following components of the HCBS requirements:

- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint. In limited circumstances, some individuals may need appropriate supports that include restraints. Restraints must meet all requirements set forth in the 1915(k) or 1915(i), as applicable, ORS, and OARs.
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- The unit or dwelling can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, substantially similar responsibilities and protections from eviction.
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- The setting is physically accessible to the individual.

Based on the initial regulatory assessment, Oregon, with stakeholder and public input, drafted and finalized an over-arching Oregon Administrative Rule that governs HCBS setting requirements across the three delivery systems. Oregon Administrative Rule Chapter 411, Division 004 ([http://arcweb.sos.state.or.us/pages/rules/oars\\_400/oar\\_411/411\\_004.html](http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_411/411_004.html)) became effective on January 1, 2016 as identified in the Statewide Transition Plan timeline.

Additionally, each service delivery system has amended specific program rules for full alignment/compliance with the over-arching OAR for all HCBS settings and federal HCBS settings regulations.

With the implementation of OAR Chapter 411, Division 004 and revised program-specific rules, DHS and OHA have determined that Oregon's regulations align/comply with the HCBS regulations.

Regulations governing the following settings fully comply with the federal requirements (see Appendix C for funding authority detail):

- APD Certified Adult Day Services;
- APD Assisted Living Facilities (includes endorsed Memory Care Facilities);
- APD Residential Care Facilities (includes endorsed Memory Care Facilities);
- APD Specialized Living Programs;
- APD Adult Foster Homes;
- HSD Adult Foster Homes;
- HSD Residential Treatment Homes;
- HSD Residential Treatment Facilities;
- ODDS Licensed/Certified Community Living Supports – Facility-based;
- ODDS Licensed/Certified Employment Services (Community-Based Job Coaching, Job Development, Discovery, Small Group, Employment Path Community, and Facility-Based Employment Path);
- ODDS Supported Living;
- ODDS Adult Foster Homes;
- ODDS Children's Foster Homes; and
- ODDS Group Care Homes.

Specific changes found necessary to 1915(c) waivers, and 1915(i) and 1915(k) State Plan Amendments will occur after the State completes the site specific assessment phase.

To demonstrate Oregon's current level of regulatory compliance with the HCBS regulation, OHA and DHS have created a crosswalk that clearly outlines:

- o how each section of the regulations aligns with the HCBS regulation;
- o the title, code, and sub-code for each policy identified;
- a general description of each policy and its relevance to the HCBS regulation; and
- o key aspects of the HCBS regulation that should be taken into consideration when reviewing the specific policy.

The crosswalk replaces the global scorecard as Oregon's final determination of systemic regulatory compliance. The crosswalk can be found in Appendix E below.

Though Oregon's regulations fully align/comply with the HCBS regulation, during the site specific assessment and remediation phases, (Phases II through IV), DHS and OHA will work to assure that each provider-owned, controlled or operated residential site meets the following additional requirements:

- Each individual has privacy in their sleeping or living unit.
- Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
- Individuals sharing units have a choice of roommates in that setting.
- Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- Individuals receiving services in residential setting are able to have visitors of their choosing at any time.

Certain non-residential sites may need to adapt and change to comply with the HCBS regulations.

Specific sites or service provider programs that cannot or will not be modified will be removed from the HCBS program. Non-residential service providers have until September 1, 2018, per OARs, to make all necessary changes. This deadline allows sufficient time for DHS and OHA to assist individuals in transitioning to other settings that comply with HCBS requirements before March 2019.

Additionally, OAR 411-004-0030(2)(c)(C) requires that individuals must have an option to use employment and day services in a non-disability specific setting and that setting option must be documented in the individual's person-centered service plan.

Phase II. Statewide Training and Education Efforts (July- 2014 – March 2019)

Individual, Provider and Service Delivery System Education – Overview

Throughout this section of the Plan, the term "Stakeholders" is used. As stated above in the "Statewide Transition Plan Preparation" section, membership of the HCBS Transition Stakeholder Group (Stakeholders) includes individuals receiving services, family members, advocates, providers and service delivery system representatives.

In addition to the stakeholders specifically designated to address HCBS implementation, DHS and OHA programs have a multitude of stakeholder groups which are convened to address policy and operational components of the service delivery programs. HCBS concepts and compliance components overlap into these stakeholder efforts which allows for additional opportunities for education and engagement with the Oregon community, including individuals, advocates, and family members of persons receiving services.

DHS and OHA have developed and implemented a variety of ways to educate Stakeholders and the broader public. These methods include, but are not limited to, the use of electronic media and community meetings. DHS and OHA developed a website designed to provide information and training materials in order to educate and keep Stakeholders and the broader community informed about the HCBS regulation and the State's progress towards achieving full compliance in its HCBS programs. Oregon's HCBS website address <http://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCBS/Pages/index.aspx>. Training and technical assistance materials found on the HCBS website include fact sheets and Frequently Asked Questions that are updated on a regular basis.

The HCBS website allows the broader community to have continuous input into the transition process and progress of the State and its HCBS settings. Individuals and community members may subscribe to the HCBS website which results in alerts when the site is updated or new information is posted.

As updates to the Transition Plan, systemic compliance and site specific compliance occur the HCBS website is updated with current materials and information. Stakeholders, interested parties, and the broader public are able to provide feedback on the Transition Plan as well as the State's and providers' progress toward full compliance with the HCBS regulation. Individuals may obtain non-electronic copies of all materials posted on the web and the Statewide Transition Plan by contacting their assigned person-centered service plan coordinator, local field office, or DHS and OHA Central Office staff. Information is also provided regarding how to obtain non-electronic copies of the Statewide Transition Plan and web materials at community meetings held by the State and training/technical assistance presentations provided by the State. Public insight and input, based on their individual experience, into the actual level of site specific compliance is vital as DHS and OHA move towards full compliance with the HCBS regulation.

In another effort to facilitate active communication and collaboration, DHS and OHA created and publicized an email address specifically for questions and feedback relating to the HCBS regulation, Transition Plan, State processes, and state and provider progress toward full compliance. The email box is monitored on a regular basis by designated State staff to address questions, comments, and requests that are received. The email address is [HCBS.Oregon@dhsoha.state.or.us](mailto:HCBS.Oregon@dhsoha.state.or.us). There is a link from the HCBS website to the HCBS email address so that people can easily ask questions and provide comments.

Additionally, each program has dedicated efforts to engage with its program-specific stakeholder community. This includes director's messages from specific service delivery systems. These messages are electronic communications broadcasted through email to individuals, family members, advocates, providers, community partners, and service delivery system representatives. This direct communication provides updates, education, information, and links to resources. In stakeholder efforts, individuals and advocates have a vocal role in providing perspective and insight into strategies being developed to further support outreach efforts.

DHS and OHA have concentrated outreach and education efforts to service delivery system support roles which have direct engagement with service recipients and their families. Outreach and education efforts include providing foundational education and technical assistance using materials developed by DHS, OHA and Stakeholders, serving as a platform so that case managers and providers can offer education and support to individuals receiving services in the most effective and meaningful manner possible. Due to the diverse nature and complexity of individual supports, DHS and OHA are working diligently in providing training and support to the service field so that case managers and providers have the resources to effectively provide the education and outreach in the most appropriate manner possible.

Combined Individual, Family, and Provider Education Provided Jointly by DHS and OHA (January 2014 – March 2019)  
DHS and OHA, with input from the HCBS Transition Stakeholder Group, develop and issue robust educational and technical assistance materials including fact sheets, frequently asked questions (FAQs), and responses to questions from stakeholders and the broader public. These materials are published on Oregon's HCBS website. All materials posted on the HCBS website are updated regularly and provided at trainings. The website address is <http://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCBS/Pages/index.aspx>.

Beginning in September 2015, DHS and OHA hosted regional information forums throughout the state. Training activities and materials focused on the HCBS regulation and information regarding the Provider Self-Assessment Tool and the Individual Experience Assessment. At the advice of the Stakeholders, DHS and OHA invited providers, consumers, family members and delivery system staff members to the same training to ensure that the information is shared consistently to everyone. Trainings were held during the day and evenings to facilitate attendance. Announcements regarding the forums were made through DHS and OHA press releases, on Facebook and Twitter, via DHS, and APD and ODDS Director's Messages. Response to the trainings was favorable. Attendees consisted of individuals, family-members, advocates and providers across the three service delivery systems.

DHS and OHA regional information forum locations and attendance is described below. In order to maximize provider participation, DHS and OHA allowed the provider's attendance to apply toward annual Continued Learning Education

(CLE) requirements. Providers were given credits toward CLE for attending a forum.

Adults: 20 forums (two at each of the following locations) with 746 attendees (332 providers who received CLE credit; 414 others):

- Astoria (9/30/15) – 14 attended [7 providers who received CLE credit & 7 others];
- Bend (08/31/15) – 47 attended [22 providers who received CLE credit & 25 others];
- Coos Bay (09/23/15) – 37 attended [26 providers who received CLE credit & 11 others];
- Eugene (09/28/15) – 107 attended [54 providers who received CLE credit & 53 others];
- Hillsboro (09/03/15) – 71 attended [25 providers who received CLE credit & 46 others];
- Salem/Keizer (09/02/15) – 104 attended [28 providers who received CLE credit & 76 others];
- Medford (09/22/15) – 162 attended [87 providers who received CLE credit & 75 others];
- Ontario (09/14/15) – 26 attended [6 providers who received CLE credit & 20 others];
- Pendleton (09/10/15) – 44 attended [16 providers who received CLE credit & 28 others];
- Portland (10/01/15) – 134 attended [61 providers who received CLE credit & 73 others].

In collaboration with Stakeholders, additional training for individuals/consumers, family members, guardians/representatives and providers is continuously being developed and disseminated based on the results of various compliance activities conducted by the State and the service delivery systems. Educational materials explain the HCBS regulation and how the requirements must be addressed throughout the State's transition period and ongoing. Educational materials also explain the impact of the HCBS regulation and how programs and services are to be integrated in the community and that individuals have the right to access the broader community in which they live. The information is routinely updated and posted on the HCBS website.

Targeted training and education materials regarding individual's rights, protections, community inclusion, individual modifications to the conditions, called "Individually Based Limitations to the Rules" in Oregon, are also being created and will be implemented. Trainings are delivered to interested groups throughout the state when education or technical assistance requests are made. DHS and OHA continue to engage Stakeholders to develop educational materials on how to safely meet the needs and rights of all individuals receiving services within the new requirements.

Further outreach occurred when DHS and OHA hosted two rule advisory committees (RAC) during promulgation of the State's overarching HCBS OAR. RAC invitations were sent to the statewide HCBS stakeholder committee, individuals/consumers, family members, providers, advocates, self-advocates, DHS and OHA service delivery systems, the Service Employees International Union, the State's protection and advocacy agency, and the Long-Term Care Ombudsman.

During the rulemaking public comment period, in addition to the parties noted above being notified of the public comment period, the general public was notified through news releases posted to FlashNews.net and News releases and documents sent to all service delivery systems local field offices for posting. Information was also posted in the Oregon Bulletin, on the State's HCBS website, and DHS' and OHA's service delivery systems' Facebook and Twitter accounts.

Provider-specific information meetings and trainings (July 2014 – September 2018)

DHS and OHA began meeting with providers and provider associations in July 2014 to inform them of the new regulations, Oregon's conceptual Transition Plan, and to give providers the opportunities to ask questions and provide initial process input. DHS and OHA have continued and will continue to meet with providers and their associations throughout the transition time period. DHS and OHA have also continuously recommended that providers hold resident and family meetings to discuss the HCBS regulations and their impact.

Additionally, as these are the homes of the individuals we serve, DHS and OHA have provided regulatory guidance to providers on the requirement that all provider-owned, operated, or controlled residential settings maintain a "home-like" quality.

Delivery System Education (November 2014 – March 2019)

DHS and OHA are ensuring that delivery system staff members (person-centered service plan coordinators, licensing staff, and protective service staff) are receiving additional training on Person-Centered Planning philosophy and practice, including the empowerment of the individual to fully understand the full range of options available to them, and their rights in making individual choices. The trainings stress that individuals have the right to select where they live and receive services from the full array of available options in Oregon, including services and supports in their own or family homes. The training includes curricula on supporting informed choice, identifies areas that providers must address and supports implementation of the Transition Plan. It also includes individuals' rights, protections, person-centered thinking, and community inclusion.

Trainings and materials provided to case management entities and providers are presented with the intent and expectation that persons in these roles will use the information to educate and support individuals in understanding and exercising the HCBS freedoms and protections.

Program-specific Trainings and Public Engagement

DHS, APD: APD will convene focus groups for consumers to help them understand the changes resulting from the new HCBS requirements and to elicit their feedback and insights. Training and collaboration has also occurred with advocacy organizations such the Long Term Care Ombudsman. The goal is to engage all interested parties in assisting Oregon in reaching full compliance with HCBS and in identifying areas of concern and gaps in our current services.

APD has provided HCBS training for the following entities on the dates listed:

- 06/17/15 - Oregon Health Care Association Assisted Living Facilities (ALF)/Residential Care Facilities (RCF) Council; • 10/15/15 - Leading Age Conference in Portland;
- 10/28/15 - Adult Foster Homes (AFH) Licensors in The Dalles; • 11/10/15 - AFH Licensors in Hillsboro; • 11/15/15 - HCBS 101 for AFH Licensors in Eugene; • 12/10/15 - Provider Survey calls; • 12/11/15 - Provider Survey calls; • 01/11/16 - Long-Term Care Ombudsman; • 02/02/16 - LeadingAge; • 04/27/16 - LSA Annual Conference in MN (panelist); • 05/19/16 - OR Dietetics in Health Care Community; • 07/18/16 - APD Surveyors (ALF/RCF); • 09/20/16 - Oregon Health Care Association 2016 Convention; • 09/21/16 - APD Safety, Oversight & Quality, Licensing Complaint Unit; • 09/22/16 - Independent Adult Care Home Association (Adult Foster Home) Conference in Clackamas ; • 10/05/16 - Independent Adult Care Home Association (Adult Foster Home) Conference in Medford.

Additionally, APD has been providing ongoing HCBS training and technical assistance at regularly scheduled APD Case Manager and Managers' meetings. Trainings have occurred:

- 10/06/15 - Case Manager Essentials; • 11/05/15 - Case Manager Essentials; • 01/14/16 - Case Manager Essentials; • 02/23/16 - 101 Person-Centered Service Planning; • 04/07/16 - Case Manager Essentials; • 08/17/16 - 101 Person-Centered Service Planning

Phase III. Provider Self-Assessment and Individual Experience Assessment (August 2015 – September 2018)

Provider Self-Assessment Tool (July 2015 – November 2015)

In Phase I. of the Transition Plan, DHS and OHA described how they assessed regulatory compliance with the settings requirements for each type of provider-owned, controlled, or operated HCBS setting authorized and funded under 1915(c) waivers, and 1915(i) and 1915(k) State Plan Options. Phase III of the Transition Plan details how DHS and OHA will determine compliance with the settings requirements for individual sites within each type of provider-owned, controlled, or operated HCBS setting (e.g. Foster Homes, ALFs, RTFs, non-residential, etc.)

In consultation with Stakeholders and partners, DHS and OHA developed a Provider Self-Assessment Tool (PSAT) for providers of provider-owned, controlled, or operated residential and non-residential settings. DHS and OHA utilized an existing contract held by OHA to conduct the Provider Self-Assessment Tool (PSAT) surveys. The contracted entity contacted every provider or provider agency that provides HCBS in a provider-owned, controlled or operated residential setting. The provider of each site received a web link to the PSAT with instructions and required timelines for completion. HCBS providers were encouraged to complete the PSAT online. If the provider was unable to complete the PSAT online, paper PSATs were available upon the provider's request. Every provider or provider agency of HCBS in provider-owned, controlled, or operated settings was required to complete a PSAT for each individual HCBS site they operate or control. Providers were encouraged to include the individuals receiving services, their family members/representatives, advocates and others in their assessment process. DHS and OHA provided guidance to providers on how to accomplish this activity. Some of the guidance included fact sheets, instructions, and FAQs.

Providers were required to complete and return the PSAT to DHS and OHA within 60 calendar days of receipt. The contracted entity conducted follow-up calls to providers and provider agencies to ensure completion of the PSAT. While there is not a financial penalty levied against a provider for failing to complete a PSAT, failure to complete a survey will require more costly and intrusive efforts by DHS and OHA to gather the same information.

Individual Experience Assessment (July 2015 – November 2015)

DHS and OHA do not assume any of the individual HCBS sites meet the new regulations. To validate both DHS's and OHA's initial regulatory assessment and the provider self-assessment results, DHS and OHA are actively engaging with individuals receiving Medicaid-funded HCBS as specified in this plan, their families and their advocacy organizations on an ongoing basis to gather their opinion and insight on how providers are complying with the HCBS requirements.

In consultation with Stakeholders, DHS and OHA developed an Individual Experience Assessment (IEA) for individuals receiving Medicaid-funded HCBS services in provider-owned, controlled, or operated residential settings and non-residential settings. In addition to questions about residential settings, the IEA contains questions specifically related to employment and day services. The IEA focuses primarily on whether the individual feels his or her service experiences align with what is required in the settings requirements. The questions asked in the IEA are very similar to those asked in the PSAT, but worded more simply. The IEA and PSAT were conducted simultaneously so the results were comparable in time.

DHS and OHA utilized an existing contract held by OHA to conduct the IEA and the Provider Self-Assessment Tool as described above. The contracted entity sent the IEA to every individual receiving Medicaid-funded HCBS in a provider-owned, controlled or operated residential setting. Individuals had the choice of completing the IEA online or via paper. Individuals were not required to complete the IEA but, with advice and feedback from Stakeholders and the contracted entity, DHS and OHA determined ways to maximize individual participation in the IEA process. In the event the individual did not respond to the initial survey, the contracted entity contacted individuals via mail up to three additional times to encourage participation and offer technical assistance. A toll-free phone line was also established for individuals to call if they required assistance in completing the IEA. Information regarding the IEA was also presented at each regional forum conducted by DHS and OHA.

During the analysis phase of IEA results, DHS and OHA has gained vital insight about how individuals receiving services perceive their experiences both with the service delivery system and their service provider. Additionally, the IEA asked if

the individual felt that they were able to select their services from all available service options and all available providers. Responses to critical questions related to the additional requirements for provider-owned, controlled, or operated settings have provided DHS and OHA with understanding of actual on-the-ground compliance specific to each site. As described below, each IEA is connected to the PSAT for the specific program or provider from which the individual receives services. The IEA indicates if it was completed by the individual, the family, the individual's guardian, or others.

DHS and OHA provided feedback to the provider, based on their analysis and evaluation of the IEA, and required them to address the findings in their final adaptation plan.

Validation of Providers' Self-Assessment (November 2015 – December 2016)

DHS and OHA are using a variety of ways to validate the PSAT. The first step is the IEA. The IEA and the PSAT contain a unique identifier that allows the contracted entity to match the IEA response with the relevant PSAT for comparison. The unique number does not contain any identifiable protected health or personal information. DHS, OHA and the contracted entity made every effort to obtain responses from at least one individual residing at each provider site. As mentioned above, the IEA response will validate or contradict the provider's self-assessment. If there is not a substantial number of IEA responses, DHS and OHA will review and validate the PSAT response during the service delivery system and licensing site-review process.

Through ongoing education, technical assistance efforts, and public input, DHS and OHA will be able to corroborate information provided by providers and individuals receiving HCBS. DHS and OHA will continue to provide and publicize ongoing opportunities for the public to submit feedback on providers' compliance and/or progress. As a key component, DHS and OHA have asked advocacy organizations, such as the Oregon Long Term Care Ombudsman, to inform DHS and OHA if the Ombudsmen or other advocates have concerns about providers' attestations.

DHS and OHA are leveraging existing organizational partners such as the Governor's Advocacy Office, adult protective service staff, licensing staff and person-centered service plan coordinators to assist in validation of assessment results and ongoing provider compliance. Staff from these entities will report concerns or areas of inconsistency. The reports from these staff members will allow the centralized HCBS team to compare complaints, issues and allegations against providers. DHS and OHA received the majority of results of the completed PSATs and IEAs on 02/05/16. DHS and OHA expect to analyze approximately 4,700 completed PSATs. IEAs were sent to approximately 18,000 individuals receiving services in provider-owned, controlled, or operated residential settings and non-residential settings funded by 1915(c), 1915(i), and/or 1915(k). Due to the rate of return of IEAs, DHS and OHA took approximately 3 months to compile, analyze and compare the results of the PSATs and IEAs.

After IEA and PSAT results were compiled, analyzed, and compared, DHS and OHA preliminarily sorted settings into the following categories:

- Settings that are compliant;
- Settings which will be compliant with remediation;
- Setting is presumptively non-HCBS and will require heightened scrutiny;
- Setting cannot meet the federal requirements and must be removed from HCBS program;
- Setting is institutional (SNF, IMD, Hospital (Oregon does not operate ICF/ID)).

After sorting, DHS and OHA will amend the Transition Plan to include assessment results, analysis, plan for remediation activities, and identification of those sites (identified as of November 1, 2016) for which DHS and OHA will be submitting evidence and requesting CMS' heightened scrutiny. DHS and OHA anticipate that, based on regular licensing/certification and other on-site visits, the identification of sites requiring heightened scrutiny and submission of evidence to CMS will be a rolling, ongoing process. The amended plan will also include the aggregated number of sites that are sorted into the categories listed above. Oregon anticipates submitting its amended Transition Plan with site-specific assessment information on January 3, 2017.

Prior to the January 3, 2017 submission to CMS of the amended Transition Plan and identification of sites (as of November 1, 2016) which have definitely been determined to require heightened scrutiny, DHS and OHA will commence a 30 calendar day public notice and comment period. The public notice will include information about how individuals can request a printed copy of the amended Transition Plan and provide input on those sites identified which will require heightened scrutiny. Throughout the transition period, prior to submission of evidence packages to CMS, DHS and OHA will commence 30 calendar day public notice and comment periods of sites determined to require heightened scrutiny.

Phase IV. Heightened Scrutiny Process – Initial and Ongoing (October 2014 – September 2018)

State's Review and Process for Heightened Scrutiny Submission to CMS (October 2014 – September 2018)

Throughout Phase III of the Statewide Transition Plan, DHS and OHA will assess each site to determine if it meets the HCBS settings requirements or requires CMS's Heightened Scrutiny. Heightened scrutiny assessment activities include:

- Conducting an initial review of licensing and service delivery system records to determine if the site is in the building of, on the grounds of, or adjacent to an institution. (October 2014)
- Working with stakeholders to create specific criteria and site characteristics for identifying which sites will require Heightened Scrutiny (October 2014 -June 2015).
- Using the Provider Self-Assessment Tool (PSAT), Individual Experience Assessment (IEA) responses, and additional activities to determine and propose if a site meets the definition of an HCBS site. (September 2015 – April 2016)
- Notifying identified affected providers of State's determination that provider's site(s) may have to go through the Heightened Scrutiny process in order to comply. (May 2016)

- Requiring identified providers of sites that appear to require heightened scrutiny to submit evidence to the State rebutting that presumption. (May 2016 –August 2016)
- Conducting on-site review of sites determined to require heightened scrutiny. (May 2016 – September 2016)
- Determining, based on evidence provided and results of onsite review, if sufficient evidence was provided to seek heightened scrutiny from CMS or if the site does not meet HCBS requirements. (September 2016 - November 2016)
- Compiling a report of the aggregated settings presumed to require heightened scrutiny. (July 2016 – November 2016)
- Commencing public notice and comment period including posting information on each service site that has been determined (as of November 1, 2016) to require CMS’ Heightened Scrutiny. Information will be posted both on Oregon’s HCBS website and will be made available in non-electronic format to those requesting. (November 2016 - December 2016)
- Revising Transition Plan to address public input, if necessary. (December 2016)
- Submitting amended Transition Plan to CMS including evidence and justification of individual sites (identified as of November 1, 2016) that appear presumptively non-HCBS for CMS’ Heightened Scrutiny. (January 2017)
- Providing opportunity for sites to request an Administrative Review of DHS’s and OHA’s determination that a site does not meet HCBS requirements and will not go through CMS’s heightened scrutiny process. (January 2017 – February 2017)
- Expected receipt of CMS response. (February 2017)
- Determining and implementing ongoing remediation strategies and next steps. (July 2016 – September 2018)
- Implement ongoing, rolling process for submission of evidence to CMS of sites determined to require heightened scrutiny. (December 2016 – Ongoing)

The State will submit evidence to CMS for heightened scrutiny in its amended plan for the following sites:

1. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building located on the grounds of, or immediately adjacent to, a public institution, which the state believes overcomes the institutional presumption and meets the requirements of a home and community based setting.
2. Any setting regardless of location that has the effect of isolating individuals receiving Medicaid home and community-based services (HCBS) from the broader community.

To address settings that may fall into category 2, the State has identified “red flag” responses to specific questions asked in the Provider Self-Assessment Tool and Individual Experience Assessment that indicate that a site may potentially have institutional qualities due to the effect of isolating an individual receiving HCBS from the broader community. The questions asked by the State on the PSAT and IEA that may indicate isolation were derived from CMS regulatory language, guidance and suggested exploratory questions. Copies of the Provider Self-Assessment Tool and Individual Experience Assessment tool are available to CMS upon request.

A provider who has “red flag” indicators will not automatically be referred to CMS for heightened scrutiny. There are several steps that will be taken before a referral is made to CMS, including prioritizing onsite visits by the State and providing the site an opportunity to rebut the presumption of institutional qualities due to the appearance of isolating individuals from the broader community.

Upon State validation and public input, evidence of sites presumed to have the qualities of an institution due to the effect of isolation per CMS regulations, but the State determines have the qualities of HCBS settings, will be referred to CMS for heightened scrutiny. Those sites that are unable to overcome the presumption of being institutional will be addressed using the process defined in Phase V. Initial Remediation Activities.

As part of the rolling, ongoing process for heightened scrutiny, the State has considered that during the HCBS compliance and validation site visits conducted by Licensing and service delivery system staff during the transition period certain sites may be identified as having the qualities of an institution due to the effect of isolating individuals receiving HCBS from the broader community. Those sites will be addressed using the same process described above and also below in Phase V. throughout the transition period.

#### Phase V. Initial Remediation Activities (May 2015 – March 2019)

After the Provider Self-Assessment Tool results for all providers and Individual Experience Assessment results were analyzed, for those providers whose settings are anticipated to be compliant with the HCBS regulations with remediation, DHS and OHA supplied each provider who responded an initial response detailing findings and the areas that they must change to come into compliance with the regulations. Initial responses were sent by the program areas in May 2016. The initial response included required information, for providers to include in its Provider-Specific Adaptation Plan. Upon receipt of the initial response, each provider will have 30 calendar days to provide DHS and OHA additional information rebutting the findings, if they choose. This submission will trigger a review process through which a review committee will make a final determination on the areas that must be remediated. The review committee will make a final determination within 30 calendar days. DHS and OHA will then send the provider a final response detailing the review committee’s final determination and identify changes that must be addressed in the provider’s Adaptation Plan.

DHS and OHA developed evaluation criteria and requirements for the Provider-Specific Adaptation Plans. Plans that do not meet the criteria and requirements will be returned to the providers/programs for necessary changes. Providers/programs who do not agree with DHS’s and OHA’s evaluation of the Adaptation Plan may request an administrative review of the determination within 30 calendar days of receiving DHS’s and OHA’s decision. DHS and OHA will make a final decision within 30 calendar days of receiving the request for an administrative review.

Approved Adaptation Plans will be posted on the HCBS website. DHS and OHA will redact any individually identifiable or confidential information before posting.

DHS and OHA will ensure that sites are making progress towards compliance through licensing and service delivery system staff visits. A reporting mechanism will be created by DHS and OHA to allow these staff to report individual providers' progress. For sites that are not licensed, contract compliance staff will review providers annually to ensure that these provider types are meeting the requirements.

DHS and OHA will also develop a scorecard of provider's progress towards implementing the new requirements and post it on the HCBS website. This scorecard will allow the public to view the provider's assessment of their status. The scorecard will include information and findings from the PSAT, adaptation plans, and service delivery system and licensing reviews. The scorecard will highlight HCBS requirements and provide a scoring system so that the public can easily understand the State's evaluation of the provider's progress towards full compliance. The information will be sufficient for the public to assess providers' compliance and provide feedback to DHS and OHA about their individual experience with and knowledge of providers.

DHS and OHA will require that providers submit their FINAL Adaptation Plan no later than December 31, 2016. For providers needing assistance to come into compliance, DHS and OHA shall:

- Facilitate regional focus groups of providers who can talk through provider specific issues and problem-solve how to achieve compliance together. Participation will be voluntary and can include individuals and family members who may aid in the problem solving process.
- Provide direct technical assistance at the request of the provider.
- Provide information on the HCBS website to guide providers in making the necessary changes.

The state will send communication to providers of non-residential HCBS explaining the requirement that the experiences of individuals receiving HCBS in non-residential settings must be consistent with those individuals not receiving HCBS.

All providers must be in full compliance with the regulations by September 30, 2018. If, by September 30, 2018, the provider is not in full compliance, DHS and OHA will notify individuals in writing by October 15, 2018 that their current provider is not in compliance with the HCBS regulations. The notification will explain the individual's rights. It will also define options, process and timeline, including the final deadline of February 28, 2019, to help the individual make an informed choice of another site that is compliant with the regulations. Individuals will be able to select from all services and available compliant settings for which they are eligible. Upon notification to the individual, using person-centered planning processes, service delivery system staff will assist and support individuals and their representatives in identifying alternate settings, services and options and will ensure that all critical services and supports are in place prior to the individual transitioning to the chosen alternate site. Individuals may contact their service delivery system staff at any time during the transition period to discuss options, alternate settings, and other services and supports.

Providers who are not able to achieve full compliance by September 30, 2018 will be required to assist DHS and OHA in transitioning individuals by February 28, 2019 to other sites that are in compliance. At this time, DHS and OHA cannot estimate the number of individual service recipients who will be required to transition to other programs. From interaction and communications with providers, DHS and OHA anticipate the majority of providers will be in compliance prior to the final deadline. DHS and OHA will be able to provide more detailed estimates when the amended Transition Plan with site specific assessment information is submitted in January 2017.

The timeline described above allows the service delivery system staff more than 5 full months to provide notification to the individuals of the requirement to re-locate to a compliant setting, give individuals the information, opportunity and supports necessary to make an informed choice about alternate settings and supports, and transition individuals by CMS's final compliance deadline. Individuals must be transitioned to compliant sites, with all critical services and supports in place, by February 28, 2019. Medicaid contracts for providers who are not willing or able to come into compliance with the regulations will be terminated no later than February 28, 2019.

#### Phase VI. Ongoing Compliance and Oversight (May 2015 – Ongoing)

On an ongoing basis, Oregon will assess providers' progress towards compliance through reports, interviews and on-site inspections that include information from providers and individuals receiving services.

Licensing and service delivery system staff will be critical to ensuring initial and ongoing compliance and assuring providers' progress on their adaptation plans. DHS and OHA will continue to ensure that these staff members are appropriately trained on the new regulations and expectations. Additionally, ongoing surveys of individuals will ensure that providers reach compliance.

With the Stakeholders, DHS and OHA will develop processes, data elements and other aspects to measure the impact of the changes on individuals receiving services. DHS and OHA will report out the compiled data on a regular basis and post information on the HCBS website.

Once overall compliance is achieved, strategies to ensure ongoing compliance will include:

- Conducting the Individual Experience Assessment biennially;
- Building questions from the individual's experience assessment into annual service planning processes;
- Ongoing licensing inspections by licensing staff; and
- Oregon's existing quality assurance system will include ongoing HCBS setting compliance monitoring to ensure that settings continue to comply with the HCBS Setting Rule.

Throughout the Transition Plan, DHS and OHA will continue to work closely with the Stakeholders to ensure that DHS and

OHA have a robust view on the progress towards successful implementation of the Transition Plan and the changes necessary to reach lasting compliance. DHS and OHA will engage Stakeholders and other avenues to evaluate progress, identify areas of concern, and propose solutions. This transition process will be transparent to Stakeholders and the broader public.

Key Action Items timeline continued on B. Additional Needed Information (Optional)

### Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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

| Key Action Items   | Approx. Start Date<br>(first day of month) | Approx. End Date<br>(last day of month) |
|--|--|---|
| <b>Pre Plan Activities</b>   |  |   |
| Meetings with provider associations  | Jul- 14                                    | Sep- 14                                 |
| Convene a HCBS Transition Stakeholder Group  | Aug- 14                                    | Sep- 19                                 |
| HCBS Transition Stakeholder Kick-off meeting   | Aug- 14                                    | Aug- 14                                 |
| <b>Phase I- Initial Regulatory Assessment</b>  |  |   |
| Complete an initial assessment of Oregon's residential and nonresidential settings' regulatory compliance with the CFRs        | Jun- 14                                    | Jan - 15                                |
| Share scorecard with stakeholders  | Aug- 14                                    | Aug- 14 and Mar- 15                     |
| Post scorecard on Oregon HCBS Website  | Aug- 14                                    | Sep- 14 and Mar- 15                     |
| <b>Oregon Transition Plan Development and Submission</b>   |  |   |
| Write draft Transition Plan  | Aug- 14                                    | Aug- 14                                 |
| Stakeholder review of draft Transition Plan  | Aug- 14                                    | Aug- 14                                 |
| Public Comment Period: September 5, 2014   | Sep- 14                                    | Oct- 14                                 |
| End of Public Comment Period: (October 5, 2014)  | Oct- 14                                    | Oct- 14                                 |
| Transition Plan Submitted to CMS   | Oct- 14                                    | Oct- 14                                 |
| Expected response from CMS   | Jan- 15                                    | Jan- 15                                 |
| Response to CMS's Request for Additional Information   | Jan- 15                                    | Apr- 15                                 |
| Response Received from CMS   |  | Aug- 15                                 |
| State's Response to CMS's request for additional information   |  | Oct- 15                                 |
| Response Received from CMS   |  | Jan- 16                                 |
| State's Response to CMS's request for additional information   |  | Apr- 16                                 |
| <b>Phase II- Statewide Training and Education Efforts</b>  |  |   |
| Meet with providers and associations   | Jul- 14                                    | Ongoing                                 |
| Develop educational materials for individuals, providers, and Case Managers including FAQs and Fact Sheets                     | Oct- 14                                    | Ongoing                                 |
| Develop and disseminate additional training regarding rights, protections, community inclusion and modifications to conditions | Jul- 14                                    | Ongoing                                 |
| Share materials with stakeholders  | Apr- 15                                    | Ongoing                                 |
| Post materials on website  | May- 15                                    | Ongoing                                 |
| Delivery System Education Efforts  | Nov- 14                                    | Mar- 19                                 |
| Host regional training and information meetings for individuals, providers, and case managers                                  | Jun- 15                                    | Oct- 15                                 |
| <b>Phase III- Provider Self-Assessment and Individual Experience Assessment</b>  |  |   |
| Provider Self-Assessment   |  |   |
| Develop Provider Self-Assessment Tool (residential and nonresidential providers)   | Oct- 14                                    | Jul- 15                                 |
| Share with Transition Stakeholder Group  | Oct- 15                                    | Jul- 15                                 |
| Develop online survey tool   | Jul- 15                                    | Aug- 15                                 |
| Send provider self-assessment to residential and non-residential providers   | Sep- 15                                    | Sep- 15                                 |

|  |         |         |
|--|---------|---------|
| Provider Self-Assessments completed and returned to State  | Sep- 15 | Feb- 16 |
| Individual Experience Assessment   |         |         |
| Develop a survey for individuals receiving services  | Oct- 14 | Jul- 15 |
| Share survey with Transition Stakeholder Group   | Oct- 14 | Jul- 15 |
| Develop online survey tool   | Jul- 15 | Aug- 15 |
| Send Individual Experience Assessments to individuals receiving HCBS   | Sep- 15 | Dec- 15 |
| State and partners to conduct individual assessments, as necessary (in-person, phone)  | Sep- 15 | Sep- 15 |
| Provide technical assistance to individuals  | Sep- 15 | Dec- 15 |
| Individual Experience Assessments completed and returned to State  | Sep- 15 | Feb- 16 |
| Provider Self-Assessment and Individual Experience Assessment Results and Responses  |         |         |
| State receives responses from PSATs and IEAs   | Feb- 16 | Feb- 16 |
| State evaluates Individual Experience Assessments and Provider Self-Assessments (comparison and validation of results from both using unique identifier that connects site with individual)        |         | Feb- 16 |
| 16   | Apr- 16 |         |
| State solicits input from advocacy organizations and existing organizational partners to assist in validation of results   | Mar- 16 | May- 16 |
| State to sort settings into compliance categories  | Mar- 16 | Apr- 16 |
| State to provide initial feedback and recommendations on areas of improvement to residential and non-residential providers   | Nov- 15 | May- 16 |
| Ongoing education and technical assistance efforts, and public input   | Sep- 15 | Ongoing |
| Submission of Amended Global Transition Plan   |         |         |
| State evaluates Individual Experience Assessments and Provider Self-Assessments (comparison and validation of results from both using unique identifier that connects site with individual)        |         | Feb- 16 |
| 16   | Apr- 16 |         |
| State identifies necessary Transition Plan changes   | Apr- 16 | Nov- 16 |
| State identifies (as of November 1, 2016) settings that require heightened scrutiny  | Sep- 16 | Nov- 16 |
| State amends Statewide Transition Plan   | Sep- 16 | Nov- 16 |
| Stakeholder review of draft Transition Plan  | Oct- 16 | Oct- 16 |
| 30- day Public Comment Period  | Nov- 16 | Dec- 16 |
| Revisions to Statewide Transition Plan based on public input   | Dec- 16 | Dec- 16 |
| Amended Statewide Transition Plan Submitted to CMS   | Jan- 17 | Jan- 17 |
| Expected response from CMS   | Feb- 17 | Feb- 17 |
| Phase IV. Heightened Scrutiny Process - Initial  |         |         |
| State uses the provider assessment, IEA responses, and additional criteria to determine and propose if a site meets the definition of an HCBS site   | Feb- 16 | Jun- 16 |
| State notifies sites that, as of November 1, 2016, require CMS' Heightened Scrutiny  | May- 16 | Oct- 16 |
| Providers requiring Heightened Scrutiny submit evidence to the State rebutting presumption of non-HCBS   | May- 16 | Oct- 16 |
| State conducts on-site reviews of settings identified (as of November 1, 2016) to require heightened scrutiny per CMS's regulations  | May- 16 | Sep- 16 |
| State determines, based on evidence provided and results of onsite review, if sufficient evidence was provided to seek heightened scrutiny from CMS or if the site does not meet HCBS requirements |         | Sep- 16 |
| 16   | Nov- 16 |         |
| State compiles aggregated report of sites requiring heightened scrutiny  | Jul- 16 | Nov- 16 |
| Provide opportunity for sites determined not to be HCBS to request an administrative review by DHS and OHA   | Jan- 17 | Feb- 17 |
| State commences public notice and comment period for amended Transition Plan and sites determined to require CMS' heightened scrutiny  |         |         |

|  |         |         |         |
|--|---------|---------|---------|
|  | Nov- 16 | Dec- 16 |         |
| State addresses public input/comment   |         | Dec- 16 | Dec- 16 |
| State submits amended Transition Plan and evidence to CMS for each setting that is presumed to be non-HCB but State is requesting CMS' heightened scrutiny   |         |         |         |
| Expected response from CMS   | Jan- 17 | Jan- 17 | Feb- 17 |
| Heightened Scrutiny Process - Ongoing (rolling process)  |         |         |         |
| State notifies sites that, as a result of onsite visits, have been identified as requiring CMS' Heightened Scrutiny  | Dec- 16 | Ongoing |         |
| Providers requiring Heightened Scrutiny submit evidence to the State rebutting presumption of non-HCBS   | Dec- 16 | Ongoing |         |
| State determines, based on evidence provided and results of onsite review, if sufficient evidence was provided to seek heightened scrutiny from CMS or if the site does not meet HCBS requirements |         |         | Dec- 16 |
| State commences public notice and comment period for amended Transition Plan and sites determined to require CMS' heightened scrutiny  |         |         |         |
| State addresses public input/comment   | Dec- 16 | Ongoing |         |
| State submits evidence to CMS for each setting that is presumed to be non-HCB but State is requesting CMS' heightened scrutiny   |         | Dec- 16 | Ongoing |
| Expected response from CMS   | Dec- 16 | Ongoing | Ongoing |
| Phase V- Remediation Activities  |         |         |         |
| Update website to guide providers in making the necessary changes.   | May- 15 |         | Sep- 18 |
| Develop with Stakeholders an advisory panel and Adaptation Plan review criteria  | May- 15 | Dec- 15 |         |
| Develop policies and procedures for Quality Assurance and Licensing staff to check progress on their adaptation plans.   | May- 15 | Jan- 16 |         |
| Finalization of over-arching HCBS OAR  |         | Jan- 16 | Jan- 16 |
| Finalization of program-specific OARs  |         | Jan- 16 | Sep- 16 |
| Service Delivery Systems and OLRO conduct onsite reviews   |         | Jan- 16 | Sep- 18 |
| Providers submit Adaptation Plans addressing State's findings  |         | May- 16 | Jun- 16 |
| State and advisory panel review providers' Adaptation Plan and provides approval or denial of Plan   | Jul- 16 | Aug- 16 |         |
| Providers may appeal the State's denial  |         | Sep- 16 | Sep- 16 |
| Providers submit FINAL Adaptation Plan addressing State's findings   |         | Nov- 16 | Dec- 16 |
| Develop a comprehensive scorecard of provider's compliance activities and outcomes   | Jan- 17 | Feb- 17 |         |
| Post scorecard on website  | Mar- 17 | Mar- 17 |         |
| Gather public input on provider's scorecard  |         | Apr- 17 | May- 17 |
| State will review and address, as appropriate, public input on provider's scorecard.   | May- 17 | Jun- 17 |         |
| State will update provider's scorecard with progress toward compliance   |         | Jun- 17 | Sep- 18 |
| Gather ongoing public input on provider's progress toward compliance.  |         | May- 17 | Sep- 18 |
| Notify Medicaid providers of non-compliance with intent to move individuals and terminate contract and license   | Sep- 18 | Sep- 18 |         |
| Notify individuals of their need to transition to alternative settings   |         | Oct- 18 | Oct- 18 |
| Assist individuals in finding, selecting and transitioning to alternative settings   | Oct- 18 | Feb- 19 |         |
| Terminate Medicaid contracts with non-compliant providers  |         | Mar- 19 | Mar- 19 |
| OAR, 1915(c) waivers, and 1915(i) and 1915(k) State Plan Amendment (SPA) Changes   |         |         |         |
| Assess OARs, waivers, and SPAs for needed changes  |         | Oct- 14 | Apr- 15 |
| Work with stakeholders to identify and address necessary OAR, waivers, and SPA changes   |         |         |         |

|  |         |         |         |
|--|---------|---------|---------|
|  | Apr- 15 | Oct- 15 |         |
| Conduct formal rule making process   |         |         | Jan- 16 |
| Finalization of over-arching HCBS OAR  | Jun- 15 |         | Jan- 16 |
| Finalization of program-specific OARs  | Jan- 16 |         | Sep- 16 |
| Amendment of over-arching HCBS OAR as described in Appendix E  |         | Jan- 17 | Jan- 17 |
| Public Notice and Submission of any necessary waiver amendments and SPAs.  | Mar- 17 |         | Dec- 17 |
| <b>Modifications to Conditions (Individually Based Limitations to the Rules)</b>   |         |         |         |
| Develop policies and procedures on implementation of modifications to conditions contained in individual service plan                                      | Jan- 15 | Dec- 15 |         |
| Create expectations and a method for collecting data on an ongoing basis to measure the effectiveness of the individually based modification to conditions | Jan- 15 | Jul- 16 |         |
| Develop timeframes for review of the data and effectiveness of the modification to ensure it continues to be appropriate.                                  | Jan- 15 | Dec- 15 |         |
| <b>Phase VI- Ongoing Compliance and Oversight</b>  |         |         |         |
| Develop and implement ongoing monitoring and quality assurance processes within existing structure   | May- 15 | Mar- 19 |         |
| Service Delivery Systems and OLRO conduct onsite reviews to assure ongoing compliance  | Mar- 19 | Ongoing |         |
| 2nd Individual Experience Assessment   |         | Jul- 17 | Dec- 17 |
| 3rd Individual Experience Assessment   |         | Jul- 19 | Dec- 19 |

## Appendix A: Waiver Administration and Operation

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

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

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

- The Medical Assistance Unit.**

Specify the unit name:

*(Do not complete item A-2)*

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

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

*(Complete item A-2-a).*

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

Specify the division/unit name:

**Oregon Department of Human Services**

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The

interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

## Appendix A: Waiver Administration and Operation

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### 2. Oversight of Performance.

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

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

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

Oregon Health Authority (OHA), the single state Medicaid Agency, and the Department of Human Services (DHS), the Operating Agency, have an Intergovernmental Agreement (IGA) that contains the following oversight functions to ensure that DHS performs its assigned waiver operations and administrative functions in accordance with waiver requirements:

- Specifies that OHA maintains the authority on Medicaid costs.
- Specifies that OHA maintains authority for waiver applications, amendments and reporting requirements related to Medicaid waivers operated by DHS.
- Requires that OHA maintain oversight of DHS for the effective and efficient operation of Medicaid waiver programs and for the purpose of compliance with all required reporting and auditing of Medicaid waiver programs.
- Requires OHA and DHS to have designated staff to coordinate through the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) for development of policy and oversight of waiver functions and quality assurance measures and outcomes.
- Grants to DHS the responsibility for the operation of, and allowable Medicaid administrative activities for home and community-based waivers serving persons who are aged or physically disabled, or have developmental disabilities.
- Specifies that OHA has final approval of administrative rules and policies promulgated by DHS that govern the waivers and is responsible for authorizing the submission of waiver applications and amendments to CMS in order to secure and maintain existing and proposed waivers. DHS will provide policy, information, recommendations and participation to OHA through the MOCSC.

In addition to leadership-level meetings to address guiding policy, OHA ensures that DHS performs assigned operational and administrative functions through the following:

- Regularly scheduled meetings of the MOCSC with staff from both OHA and DHS to discuss:
  - o Information and correspondence received from CMS
  - o Proposed policy changes
  - o Waiver amendments and changes
  - o Data collection and quality assurance activities
  - o Waiver eligibility and enrollment
  - o Fiscal projections
  - o All other waiver related topics
- All policy changes related to the waivers are approved by OHA. The MOCSC will be the avenue through which policy changes are reviewed. Recommendation for approval will be provided to OHA for final approval.
- Waiver renewals, requests for amendments and 372 reports will be approved and submitted by OHA to

CMS.

- Formal correspondence with CMS is submitted by OHA. Informal correspondence with CMS is copied to OHA.

The Oregon Health Authority has oversight responsibility for all Medicaid programs, including the following functions related to HCBS waivers:

- Annual review of waiver enrollment measured against enrollment projections.
- Annual review of waiver expenditures measured against expenditure projections.
- Utilization management- OHA will review expenditures to ensure compliance with relevant statutory and regulatory authority and administrative rules and policies.
- Qualified Provider Enrollment and Termination - OHA will review provider enrollment and termination procedures and policies to ensure that Medicaid providers meet documented provider qualifications.
- Execution of Medicaid Provider Agreements - OHA will provide oversight to assure that Medicaid agreements are executed appropriately. OHA will also directly execute Medicaid agreements with providers choosing to contract directly with OHA.
- Rules, Policies, and Procedures Governing the Waiver Program- OHA will assist in the development, implementation and oversight of rules, policies and procedures governing the waiver program.
- Quality Assurance and Quality Improvement Activities - OHA will conduct its own and review DHS' waiver assurances and standards of quality and remediation activities.

The IGA formalizes OHA oversight here -

### 3.1 PROGRAM RELATED OVERSIGHT

3.1.1 Medicaid/CHIP program, projects or expenditures, which in whole or in part utilizes financial resources that are within OHA's legislative functions and duties, must be reviewed and approved by OHA. DHS will not presume OHA approval or implementation or timeline through public or other external commitments without prior approval or appropriate consultation with OHA.

3.1.2 No application, renewal, or substantive modification to a Medicaid Waiver or State Plan Amendment that affects programs identified in Schedule C of this Agreement, will be submitted to CMS for approval without prior review and approval by OHA. DHS will submit documents to OHA in a timely manner to ensure that OHA has adequate time to review and confer with DHS prior to the proposed submission date. Projects will be developed according to the process description in Paragraph 3.0 of this Article.

3.1.3 OHA exercises ultimate authority of Medicaid/CHIP programs by reviewing and approving DHS operational activities and functions related to Medicaid/CHIP programs.

3.1.4 Should OHA find evidence that any expenditure, service or delivery of services is out of alignment with relevant statutory authority, regulatory authority, State Plans, policies, program manuals or program guidance, DHS will be required to develop and present a plan of correction.

3.1.5 Medicaid/CHIP services and the delivery of services must comply with all applicable federal law including Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 as amended and the Age Discrimination Act of 1975.

3.1.6 OHA reserves the right to audit all programs, plans or expenditures covered under this Agreement.

## Appendix A: Waiver Administration and Operation

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

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

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

DHS is a contracted entity, per the OHA/DHS Inter-agency Agreement, that performs operational and administrative functions on behalf of the Medicaid Agency.

Within the OHA/DHS Inter-agency Agreement, Schedule C, OHA has designated DHS as an Organized Health Care Delivery System, as defined in 42 CFR 447.10(b). As such, DHS may contract with or enter into provider

enrollment agreements, inter-agency agreements, grants or other similar arrangements with qualified individuals, entities or units of government to furnish Medicaid/CHIP administrative or programmatic services for which DHS has responsibility. The agencies renew this agreement every two years. For this waiver, DHS contracts with local Area Agencies on Aging, among others.

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

## Appendix A: Waiver Administration and Operation

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

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

Area Agencies on Aging (AAAs) meeting the definition of an Area Agency on Aging and administered by a unit or combination of units of general purpose local government, which administers the Medicaid, financial and adult protective services, and regulatory programs of elderly individuals or adults with physical disabilities. (These may also be referred to as "Type B" or "Transfer" AAAs in this document.)

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

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

## Appendix A: Waiver Administration and Operation

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

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

## Appendix A: Waiver Administration and Operation

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

OHA will exercise oversight of Medicaid/CHIP programs by participating in related committees and approving DHS reports and documents as necessary. Each year, OHA will review and approve annual CMS 372 waiver reports for each waiver, reports of quality assurance performance outcomes across the spectrum of Medicaid state plan and waiver services offered, and reports of Medicaid policy changes planned in the near and long-term. OHA will review DHS quality control processes for Medicaid/CHIP programs managed by DHS to assure proper oversight of central office and field operations. This will include an initial review of program oversight activities during the first two

years of this agreement and a follow up review during subsequent three-year periods thereafter. OHA will designate internal staff to review the processes employed, and outcomes reported, by DHS in order to ensure prompt and accurate level of care determination, participant access to qualified providers, participant-centered service planning/delivery, enforcement of safeguards that ensure participant health and safety, and maintenance of financial accountability for all home and community-based waiver service levels.

The DHS Office of Program Integrity (OPI) 1915 Waiver Quality Assurance(QA) staff review and monitor the accuracy and consistency of waiver operational and administrative functions performed by all local field offices, including AAAs \*and Oregon Tribes\*, through two ongoing processes:

In a two-year cycle, the 1915 Waiver QA staff conducts a field review, evaluating activities in all local DHS, AAA \*and Oregon Tribal\* offices against waiver requirements such as timeliness, accuracy, appropriateness of services, services billed are actually received, compliance with State and Federal regulation, program outcomes, consumer satisfaction and cost effectiveness. The process of evaluation involves 1915 Waiver QA staff examination of a valid 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 consumer satisfaction. The 1915 Waiver QA staff records findings using a standardized tool and issues a formal finding in a report to the local office identifying trends in policy and rule application. The local office must submit a plan of correction to DHS within 30 days of receipt of this report that addresses any issues found in the 1915 Waiver QA staff report. DHS then issues a final report to the local office. DHS enters details of the review of each waiver participant's record into the Quality Management Data Base (QMDB)for tracking. APD Central Office 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 1915 Waiver QA staff include file reviews, on-site reviews, interviews and assessments with individuals receiving services, and service plan reviews. Data is entered into a database (1915 Waiver QA staff reviews).

This process is a source of ongoing data about assistance with waiver enrollment, LOC activities, participant services plans, and prior authorization of waiver services. The process also provides information, through direct observation and review of factors associated with participant outcomes and satisfaction, that aids evaluation of other functions such as dissemination of information concerning the waiver to potential enrollees, recruitment of providers, utilization management and training/technical assistance concerning waiver assurances.

OHA will designate staff review the processes employed, and outcomes reported by DHS in order to ensure prompt and accurate level of care determination, participant access to qualified providers, participant-centered service planning/delivery, enforcement of safeguards that ensure participant health and safety, and maintenance of financial accountability for all home and community-based waiver service levels.

The Medicaid/Chip Operations Coordination Steering Committee (MOCSC) is an internal leadership and governance body of OHA and DHS, chartered in accordance with the IAA. MOCSC is co-chaired by representatives of OHA and DHS appointed by the OHA/DHS Joint Operations Steering Committee (JOSC). The MOCSC provides high level oversight and decision-making on the operations of the Medicaid/CHIP programs and monitors the inter-agency 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 inter-agency 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; and
- Providing timely access, as needed by committees or work groups, to review and recommend necessary actions, including an expedited review and decision-making process to accommodate time lines.
- Referring concerns or disagreements related to decisions by the MOCSC to JOSC or JPSC as appropriate.

## Appendix A: Waiver Administration and Operation

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

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

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

| Function   | Medicaid Agency                     | Other State Operating Agency        | Contracted Entity                   | Local Non-State Entity              |
|--|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| Participant waiver enrollment  | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Waiver enrollment managed against approved limits                                    | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Waiver expenditures managed against approved levels                                  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Level of care evaluation   | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Review of Participant service plans  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Prior authorization of waiver services   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Utilization management   | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Qualified provider enrollment  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Execution of Medicaid provider agreements  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Establishment of a statewide rate methodology  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Rules, policies, procedures and information development governing the waiver program | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Quality assurance and quality improvement activities                                 | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |

## Appendix A: Waiver Administration and Operation

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

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

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

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

##### i. Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:*

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

*Where possible, include numerator/denominator.*

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

**Performance Measure:**

**PM1:Percentage of oversight of waiver amendments, renewals and financial reports. N: Number of waiver amendments, renewals and financial reports approved by OHA prior to implementation. D: Number of waiver amendments, renewals and financial reports provided by DHS.**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**PM2:Percentage of aggregated performance measure reports, trends, and remediation efforts reviewed by OHA. N: Number of aggregated performance measure reports,trends, and remediation efforts reviewed by OHA. D: Number of aggregated performance measure reports, trends, and remediation efforts generated by DHS.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

**PM3:**The number and percent of waiver amendments reviewed with Oregon’s Tribal partners prior to submission to CMS  
 $N = \text{Number of waiver amendments reviewed with Oregon’s Tribal partners prior to submission to CMS}$   
 $D = \text{Number of waiver amendments submitted to CMS.}$

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

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

**Data Source (Select one):**

**Meeting minutes**

If 'Other' is selected, specify:

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

|  |                      |  |
|--|----------------------|--|
|  | Specify:             |  |
|  | <input type="text"/> |  |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM5: Amount and percent of annual aggregate waiver expenditures that remain cost neutral**  
 N = Number and percent of waiver years D+D < =G+G D = Number of waiver years reviewed

**Data Source (Select one):**

**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM6: Delegated Function: The percent of contracted CDDPs/Brokerages/AAAs that submit timely contract monitoring reports. N= The number of contracted CDDPs/Brokerages/AAAs reporting to the state in a timely manner. D= The total number of contracted CDDPs/Brokerages/AAAs.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

|   |   |   |
|---|---|---|
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                       | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/> |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             |
|   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |   |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM7:Delegated Functions: The percent of CDDPs/Brokerages/AAAs that comply with their fiscal year waiver spending plans provided by the state. N: The number of CDDPs/Brokerages/AAAs in compliance with fiscal year waiver spending plans. D: The total number of CDDPs/Brokerages/AAAs contracted.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

|   |   |  |
|---|---|--|
|   |   | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/> |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                       | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>                  |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                              |
|   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |  |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM8: Delegated Function:** The percent of CDDPs/Brokerages/AAAs contracts that were monitored annually by contract specialists to verify contract compliance. N= The number of contracts with CDDPs/Brokerages/AAAs that were monitored. D= The number of contracts with CDDPs/Brokerages/AAAs.

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|---|--|--|
|   |  |  |

|  |  |   |
|--|--|---|
| <input type="checkbox"/> State Medicaid Agency                     | <input type="checkbox"/> Weekly                                    | <input type="checkbox"/> 100% Review  |
| <input checked="" type="checkbox"/> Operating Agency               | <input type="checkbox"/> Monthly                                   | <input checked="" type="checkbox"/> Less than 100% Review   |
| <input type="checkbox"/> Sub-State Entity                          | <input type="checkbox"/> Quarterly                                 | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval =<br>Confidence level = 95%/5%/50% |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> Annually                       | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>                                      |
|  | <input type="checkbox"/> Continuously and Ongoing                  | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>  |
|  | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> |   |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM9:Delegated Function:** The percent of CDDPs/Brokerages/AAAs that need on-site monitoring or technical assistance that receive on-site monitoring or technical assistance. **N:** The number of CDDPs/Brokerages/AAAs who received on-site monitoring or technical assistance. **D:** The number of CDDPs/Brokerages/AAAs identified to need on-site monitoring or technical assistance.

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

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

**Data Aggregation and Analysis:**

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

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

Data and reports gathered and created by DHS staff during quality reviews are reviewed and analyzed on a continuous and ongoing basis by designated OHA staff, including the OHA liaison to DHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Designated staff within OHA will review a representative sample of individual files case managed by DHS-operated field offices using a 95%/5%/50% method. For AAAs \*and Oregon Tribes\*, OHA will review a 10% sample of individual files reviewed by DHS during DHS' quality assurance reviews. Upon completion of OHA's analysis and review of DHS' quality assurance data and reports and its own quality assurance file reviews, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document DHS and OHA remediation efforts.

The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and DHS. 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.

The 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.

DHS staff address individual problems with designated OHA staff on an ongoing basis and during regularly scheduled meetings. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving 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 designated OHA staff, the OHA liaison, and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Joint Policy and Operations Steering Committee outlined above, thus informing executive management of OHA and DHS.

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

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

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. Because DHS is monitoring the performance of its contractors (AAA, \*Oregon Tribes\* and service providers) and OHA is monitoring the performance of its operating agency (DHS) and reviewing DHS' monitoring of its contractors, the timelines for corrective action and remediation taken by each agency differ.

Non-compliance will be determined by any performance measure that falls below 86% accuracy. 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)

OHA timelines for remediation:

Corrective Action Plans: Within 30 days of OHA's identification of need for plan of correction, DHS must submit a plan of correction.

Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 30 days of OHA's approval of DHS'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.

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

- No**
- Yes**

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

↑  
↓

## Appendix B: Participant Access and Eligibility

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

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

| Target Group   | Included                            | Target SubGroup               | Minimum Age | Maximum Age       |                                     |
|--|-------------------------------------|-------------------------------|-------------|-------------------|-------------------------------------|
|  |                                     |                               |             | Maximum Age Limit | No Maximum Age Limit                |
| <input checked="" type="checkbox"/> <b>Aged or Disabled, or Both - General</b>               |                                     |                               |             |                   |                                     |
|  | <input checked="" type="checkbox"/> | Aged                          | 65          |                   | <input checked="" type="checkbox"/> |
|  | <input checked="" type="checkbox"/> | Disabled (Physical)           | 18          | 64                |                                     |
|  | <input type="checkbox"/>            | Disabled (Other)              |             |                   |                                     |
| <input type="checkbox"/> <b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>    |                                     |                               |             |                   |                                     |
|  | <input type="checkbox"/>            | Brain Injury                  |             |                   | <input type="checkbox"/>            |
|  | <input type="checkbox"/>            | HIV/AIDS                      |             |                   | <input type="checkbox"/>            |
|  | <input type="checkbox"/>            | Medically Fragile             |             |                   | <input type="checkbox"/>            |
|  | <input type="checkbox"/>            | Technology Dependent          |             |                   | <input type="checkbox"/>            |
| <input type="checkbox"/> <b>Intellectual Disability or Developmental Disability, or Both</b> |                                     |                               |             |                   |                                     |
|  | <input type="checkbox"/>            | Autism                        |             |                   | <input type="checkbox"/>            |
|  | <input type="checkbox"/>            | Developmental Disability      |             |                   | <input type="checkbox"/>            |
|  | <input type="checkbox"/>            | Intellectual Disability       |             |                   | <input type="checkbox"/>            |
| <input type="checkbox"/> <b>Mental Illness</b>   |                                     |                               |             |                   |                                     |
|  | <input type="checkbox"/>            | Mental Illness                |             |                   | <input type="checkbox"/>            |
|  | <input type="checkbox"/>            | Serious Emotional Disturbance |             |                   | <input type="checkbox"/>            |

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

N/A

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

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

*Specify:*

Disabled participants reaching the maximum age limit remain in the APD waiver. There is no break in services. The APD waiver serves both Aged and Physically Disabled individuals.

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- Other**

*Specify:*

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

- The following dollar amount:**

Specify dollar amount:

**The dollar amount (*select one*)**

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

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- The following percentage that is less than 100% of the institutional average:**

Specify percent:

**Other:**

Specify:

**Appendix B: Participant Access and Eligibility**

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

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

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

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

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

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

**Other safeguard(s)**

Specify:

**Appendix B: Participant Access and Eligibility**

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

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

**Table: B-3-a**

| Waiver Year | Unduplicated Number of Participants                     |
|-------------|---|
| Year 1      | <input style="width: 100%;" type="text" value="39480"/> |
| Year 2      | <input style="width: 100%;" type="text" value="42288"/> |
| Year 3      | <input style="width: 100%;" type="text" value="44648"/> |

| Waiver Year | Unduplicated Number of Participants |
|-------------|-------------------------------------|
| Year 4      | 47864                               |
| Year 5      | 51305                               |

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

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

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

Table: B-3-b

| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
|-------------|--|
| Year 1      |  |
| Year 2      |  |
| Year 3      |  |
| Year 4      |  |
| Year 5      |  |

## Appendix B: Participant Access and Eligibility

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

- e. **Allocation of Waiver Capacity.**

*Select one:*

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

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

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

DHS offers entry to the waiver to all persons in the target populations that meet financial criteria, meet criteria for Service Priority Levels 1-13, (specified in Oregon Administrative Rules (OAR 411.015.0000 - 0100)), and do not otherwise have natural supports available to meet assessed needs. DHS determines Service Priority Levels based on needs for assistance in activities of daily living as assessed using the standardized 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. The tool also documents any natural supports available to meet any assessed needs of the participant. Natural supports are assigned tasks that are mutually agreed upon by the waiver participant and the person providing the natural support. 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.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

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

a.

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

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

2. **Miller Trust State.**

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

- No  
 Yes

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

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

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

*Select one:*

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

Specify percentage:

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

*Specify:*

All mandatory and optional SSI related group covered under the State Medicaid plan.

---

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

---

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

*Select one and complete Appendix B-5.*

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

*Check each that applies:*

- A special income level equal to:

*Select one:*

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

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

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

Select one:

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

Specify percentage amount:

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

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

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

*Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.**

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

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

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

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

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 7)

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

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

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- The following standard included under the State plan**

Select one:

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

(select one):

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

Specify the percentage:

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

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

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

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

Specify:

The allowance for the needs of waiver participants living in their own homes is calculated using the following formula:

\$500 is added to the SSI standard. The amount is calculated annually when the SSI FBR is adjusted.

Individuals in 24-hour residential settings maintain the SSI standard as the allowance for the needs of the waiver participant.

- Other**

Specify:

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

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

*Specify:*

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

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The following dollar amount:**

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

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

*Specify:*



---

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

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

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

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

*Specify:*

- Other**

*Specify:*



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

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

Select one:

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

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 7)

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

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

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

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 7)

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

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

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

##### i. Allowance for the personal needs of the waiver participant

(select one):

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

Specify percentage:

- The following dollar amount:**

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

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

Specify formula:

- Other**

*Specify:*

The allowance for the personal needs of the waiver participant is the same as the allowance under regular post-eligibility criteria as described in Appendix B-5-b.

The allowance for the needs of waiver participants living in their own homes is calculated using the following formula:

\$500 is added to the SSI standard. The amount is calculated annually when the SSI FBR is adjusted.

Individuals in 24-hour residential settings maintain the SSI standard as the allowance for the needs of the waiver participant.

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

Select one:

- Allowance is the same**  
 **Allowance is different.**

*Explanation of difference:*

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

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

Select one:

- Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*  
 **The State does not establish reasonable limits.**  
 **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## **Appendix B: Participant Access and Eligibility**

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

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

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

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

## **Appendix B: Participant Access and Eligibility**

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

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

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

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

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## Appendix B: Participant Access and Eligibility

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

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

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

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

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Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

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## Appendix B: Participant Access and Eligibility

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

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

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

#### i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- Other**  
Specify:

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

All level of care evaluations and reevaluations are conducted by qualified case managers.

DHS' minimum case manager 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).

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

Individuals must be assessed as meeting at least one of the following priority levels as defined in OAR 411-015-0010:

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

\*Definitions of levels of assistance:

**Independent:** The individual is able to accomplish the tasks of the ADL without any assistance or needs assistance less than 4 days per month.

**Assist:** Even with assistive devices, the individual requires assistance from another person with a task of the ADL at least one day each week totaling four days per month during the assessment timeframe.

**Full Assist:** Even with assistive devices, the individual is unable to accomplish any task of the ADL without the assistance of another person. This means the individual needs hands-on assistance of another person through all tasks of the activity, every time the activity is attempted.

For mobility, there are two additional levels of assistance:

(A) Minimal Assist: Even with assistive devices, the individual requires hands-on assistance from another person to ambulate outside the home or care setting at least once each week, totaling four days per month. The individual requires hands-on assistance from another person to ambulate inside their home or care setting less than one day each week.

(B) Substantial Assist: Even with assistive devices the individual requires hands-on assistance from another person to ambulate inside their home or care setting at least one day each week totaling four days per month.\*

Levels of Care are determined as a result of a comprehensive assessment, conducted by a case manager, 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 indication of the need to receive Nursing Facility level of services within the next 30 days and absent the receipt of services the person would be institutionalized due to their need. This assessment tool is used to determine Level of Care for both home and community based care and nursing facility care.

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

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

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

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

Case managers complete the initial level of care assessment and subsequent annual (at minimum) re-assessments with the individuals present and participating as much as possible. The case manager uses a laptop computer to directly record an individual's responses during the assessment, while being guided to collect additional information by triggers built into the system. The flexibility of the laptop computer also allows the case manager to conduct an assessment in the individual's home, solicit and record individual insights and preferences throughout the assessment, and include direct observations in the assessment record.

Case managers upload the assessment and updates to the DHS central database upon return to the local office.

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

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

*Specify the other schedule:*

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

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

*Specify the qualifications:*

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

DHS sends each \*local office\* a computerized list of names of individuals who must have an annual re-assessment within the next 90 days. The list includes case manager identification.

Level of Care Re-assessments must be done by the CAPS review due date or DHS will suspend payment for individual and facility providers. An overdue assessment report is available from the mainframe reporting system "View Direct" (WCM 0390-RA).

DHS mails a 14-day advance notice that a re-assessment is necessary before the end of the following month to individuals due for re-assessment. The case manager contacts the individual to schedule the evaluation/reevaluation of LOC. The individual can also contact the case manager directly at any time to schedule an evaluation/reevaluation.

The Oregon ACCESS CAPS contains Re-determination and Medical Review Due reports by local branch office and worker codes. Local \*\* offices have internal procedures to run these reports in order to meet the required review dates.

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

CAPS maintains an ongoing record of evaluations and re-evaluations and one year of narrative before the narrative is archived in the parent information system called Oregon ACCESS. Workers may retrieve this narrative when needed. CAPS assessment, reassessment and plan information remain active in the system as long as the case is open.

When a case goes inactive it will be placed in inactive status and retained in CAPS for three years. After three years, a case will automatically archive if there is no reactivation. The case and CAPS are archived indefinitely. At any point after archive, the record may be retrieved and reviewed.

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

### **Quality Improvement: Level of Care**

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

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

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

- i. Sub-Assurances:**

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

#### **Performance Measures**

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

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

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**PM10: Number and percent of waiver participants who had an approved LOC prior to waiver enrollment. N: Number of waiver participants who had an approved LOC prior to waiver enrollment D: Total number of waiver participants reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>  |
|--|---|--|
| <input type="checkbox"/> <b>State Medicaid Agency</b>  | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>  |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                  | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all AAA offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>                                    |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>  |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |  |

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

|   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input type="checkbox"/> <b>Quarterly</b>                                  | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>   |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = <input type="text"/>                                     |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during |

|  |  |                     |
|--|--|---------------------|
|  |  | DHS' review of AAAs |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |                     |

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**

**PM11: Number and percent of waiver participants who have a redetermination of LOC completed annually N: Number of waiver participants who have a redetermination of LOC that was completed annually D: Total number of waiver participants reviewed**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|---|--|--|
|   |  |  |

|   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>State Medicaid Agency</b>                     | <input type="checkbox"/> <b>Weekly</b>                                     | <input type="checkbox"/> <b>100% Review</b>   |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>               | <input type="checkbox"/> <b>Monthly</b>                                    | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input type="checkbox"/> <b>Quarterly</b>                                  | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% of all AAA offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>                                   |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>   |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>  |
|--|---|--|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>  |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated field offices. |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>  |
|  |   | <input type="checkbox"/> <b>Other</b>  |

|  |  |                                  |
|--|--|----------------------------------|
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | Specify:<br><input type="text"/> |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |                                  |

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation (check each that applies):</b> | <b>Frequency of data collection/generation (check each that applies):</b>  | <b>Sampling Approach (check each that applies):</b>   |
|--|--|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                   | <input type="checkbox"/> <b>Weekly</b>                                     | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>                                   | <input type="checkbox"/> <b>Monthly</b>                                    | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                   | <input type="checkbox"/> <b>Quarterly</b>                                  | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>          | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Aggregation and Analysis:**

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

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

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

**Performance Measures**

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

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

**Performance Measure:**

**PM12: Number and percent of LOC that were completed based on the instruments and processes in the approved waiver. N: Number of LOC that were completed based on the instruments and processes in the approved waiver D: Total number of LOCs reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

|   |  |  |
|---|--|--|
|   |  | 95%/5%/50%<br>for all AAA<br>offices.  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe<br>Group:<br><input type="text"/> |
|   | <input type="checkbox"/> <b>Continuously and<br/>Ongoing</b>               | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |  |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>  |
|--|---|--|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>  |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS operated field offices. |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe<br>Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and<br/>Ongoing</b>                        | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>  |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |  |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |   |

**Data Aggregation and Analysis:**

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

| Responsible Party for data aggregation and analysis (check each that applies): | Frequency of data aggregation and analysis (check each that applies):       |
|--|---|
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially. |

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

Data and reports gathered and created by DHS staff during quality reviews are reviewed and analyzed on a continuous and ongoing basis by designated OHA staff, including the OHA liaison to DHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Designated staff within OHA will review a representative sample of individual files case managed by DHS-operated field offices using a

95%/5%/50% method. For AAAs, OHA will review a 10% sample of individual files reviewed by DHS during DHS' quality assurance reviews. Upon completion of OHA'

analysis and review of DHS' quality assurance data and reports and its own quality assurance file reviews, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document DHS and OHA remediation efforts.

The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and DHS. 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.

The 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.

DHS staff address individual problems with designated OHA staff on an ongoing basis and during regularly scheduled meetings. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving 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 designated OHA staff, the OHA liaison, and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Joint Policy and Operations Steering Committee outlined above, thus informing executive management of OHA and DHS.

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

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

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. Because DHS is monitoring the performance of its contractors (AAA, \*Oregon Tribes\* and service providers) and OHA is monitoring the performance of its operating agency (DHS) and reviewing DHS' monitoring of its contractors, the timelines for corrective action and remediation taken by each agency differ.

Non-compliance will be determined by any performance measure that falls below 86% accuracy. 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)

OHA timelines for remediation:

Corrective Action Plans: Within 30 days of OHA’s identification of need for plan of correction, DHS must submit a plan of correction.

Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 30 days of OHA’s approval of DHS’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.

**ii. Remediation Data Aggregation**

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

| Responsible Party <i>(check each that applies):</i>   | Frequency of data aggregation and analysis<br><i>(check each that applies):</i> |
|---|---|
| <input checked="" type="checkbox"/> State Medicaid Agency   | <input type="checkbox"/> Weekly   |
| <input checked="" type="checkbox"/> Operating Agency  | <input type="checkbox"/> Monthly  |
| <input type="checkbox"/> Sub-State Entity   | <input type="checkbox"/> Quarterly  |
| <input type="checkbox"/> Other<br>Specify:<br><div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input type="checkbox"/> Annually   |
|   | <input type="checkbox"/> Continuously and Ongoing                               |
|   | <input checked="" type="checkbox"/> Other<br>Specify:<br>Biennially.            |

**c. Timelines**

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

- No  
 Yes

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

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

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

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

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

DHS assures that individuals who are eligible for services under the waiver will be informed of feasible alternatives for long-term care 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 a Nursing Facility, the individual or his or her legal representative will be:

- 1) Informed of any feasible alternatives available under the waiver and State plan; and
- 2) Given the choice of institutional, waiver and/or State plan home and community-based services.

The choice of institutional or home and community-based services is documented on form SDS 0914.

Case managers are responsible for collecting the appropriate Freedom of Choice documentation.

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

All forms and documents are maintained in case files for at least three years. The file is transferred if the individual moves to another branch. The documentation of choice is available wherever the individual receives services.

## Appendix B: Participant Access and Eligibility

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

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

When the caseload of a local DHS or AAA office consists of 35 or more non-English-speaking households that share the same language, Oregon Revised Statute 411.970 requires the Department of Human Services to provide, at that local office, written materials in that language and access to a bilingual assistance worker or caseworker fluent in both that language and English.

When a Limited English Proficient (LEP) person attempts to access waiver services, the local DHS or AAA office notifies the person that language services are available. DHS or AAA staff informs the LEP person that he or she has the option of having an interpreter without charge, or of using his or her own interpreter. Considerations are given to the circumstances of the LEP and whether there may be concerns over competency, confidentiality, privacy, or conflict of interest. DHS or AAA staff do not require LEP persons to use family members or friends as interpreters.

Many vital forms and notices (e.g. SDS 0539A-Application, SDS 0540-Notification of Planned Action with DHS 0447-Hearing Rights attached), SDS 0541-Notification of Approval with DHS 0447 attached), DHS 9001-Client Discrimination, DHS 1005-Alternate Format Notification, DHS 2099-Release of Health Information) are available for applicants and recipients in languages that are used by a significant number of individuals in the state. Most frequently, documents are translated into Russian, Vietnamese, and Spanish and are available for download from the Department’s website or paper copies are available at the local field office.

Language assistance is available for telephone conversations through a contractor.

## Appendix C: Participant Services

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

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

| Service Type      | Service                |  |  |
|-------------------|------------------------|--|--|
| Statutory Service | Waiver Case Management |  |  |
| Other Service     | Transition Services    |  |  |

## Appendix C: Participant Services

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

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

**Service Type:**

**Service:**

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

Waiver Case Management

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Waiver Case Management services are furnished to assist individuals in gaining access to needed medical, social, educational and other services. At a minimum, case management must include quarterly direct contact

with the individual waiver participant and, during the other months, monthly monitoring which will, at a minimum, include the review of records and encounter data to ensure that needed services are provided in accordance with the individual's person-centered service plan and that there is no need to update/alter the plan.

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 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, content, units of the case management services received and whether goals specified in the care plan have been achieved;
- (v) Whether the individual has declined services in the care plan;
- (vi) The need for, and occurrences of, coordination with other case managers;

- (vii) A timeline for obtaining needed services;
- (viii) A timeline for reevaluation of the plan.

The 1915(c) waiver is operated concurrently with a 1915(b)(4) waiver limiting freedom of choice of case management providers to employees of DHS, the local Area Agency on Aging \*or Oregon Tribes\*.

- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
- Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
- FFP only is available for case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

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

Prior to enrollment into the waiver, case management provided for transition services from institutional settings to community-based settings are provided under 1915(k) authority.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

| Provider Category | Provider Type Title |
|-------------------|---------------------|
| Agency            | Case Manager        |

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Waiver Case Management**

**Provider Category:**

Agency ▼

**Provider Type:**

Case Manager

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard (specify):**

Employees of agencies authorized through the 1915(b)(4) APD Case Management waiver to provide case management services.

Agencies include Department of Human Services (DHS), local Area Agencies on Aging (AAA) offices and Oregon Tribes.

Minimum qualifications for case managers:

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).

Case managers must also pass a criminal background check.

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

Local DHS and AAA offices ensure minimum qualifications are met prior to employment.

**Frequency of Verification:**

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

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

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

**Service Type:**

Other Service 

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

**Service Title:**

Transition Services

**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

16 Community Transition Services

16010 community transition services 

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

 

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

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

**Service Definition (Scope):**

Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources.

Other transition services include teaching and training unpaid caregivers; a contract RN, within the scope of the state's nurse practice act requirements, teaches/trains the individual's natural supports how to provide personal care assistance to the individual, how to provide ongoing medical treatment, or how to administer medication to support the individual when the individual moves to the in-home setting.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

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

Transition assistance payments 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. Necessary home accessibility adaptations must be made prior to the individual moving in to the in-home setting. 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.

Local offices may approve moving costs up to \$1,000 per move. Any expenditures above that amount, or for other transition services will be approved by the DHS Policy Office. Approval will be based on individual's assessed needs and the DHS policy office's determination of appropriateness and cost effectiveness.

Individuals will be able to access the moving and move-in costs benefit no more than twice annually though basic household furnishing and other items will be limited to one time per year.

This service will not overlap, supplant, or duplicate other services provided through the Medicaid State Plan, Medicaid State Plan Options, or other approved Medicaid waiver authorities.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative

Legal Guardian

**Provider Specifications:**

| Provider Category | Provider Type Title               |
|-------------------|-----------------------------------|
| Individual        | General Business Provider         |
| Individual        | Self-employed Registered Nurse    |
| Agency            | In Home Care Agency (ORS 443.305) |
| Agency            | Home Health Agency (ORS 443.005)  |

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Transition Services**

**Provider Category:**

Individual ▼

**Provider Type:**

General Business Provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Any required license, certification or other state required standard to operate the type of business relevant to the item or service being requested. For example, payments for utilities must be made to a utility provider that is authorized to operate in the State of Oregon. The utility provider maintains all appropriate licenses, certifications, etc. to operate as a utility provider in the State. Providers completing necessary home accessibility adaptations must be licensed, bonded and insured. General contractors must have current Construction Contractors Board (CCB) license.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Local AAA/DHS office.

**Frequency of Verification:**

Prior to each purchase or payment for services.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Transition Services**

**Provider Category:**

Individual ▼

**Provider Type:**

Self-employed Registered Nurse

**Provider Qualifications**

**License (specify):**

Current and unencumbered nursing license who meets Oregon State Board of Nursing licensure requirements under Oregon Revised Statute 678.010 – 410 and Oregon Administrative Rules, Standards and Scope of Practice for Licensed Nursing

**Certificate (specify):**

**Other Standard (specify):**

Who has met all rule requirements as an enrolled qualified Medicaid provider under OAR 407-120-0300- thru-0400 and OAR 410-120-1260

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

APD/OHA

**Frequency of Verification:**

Prior to payment through the MMIS system and ongoing nursing license verification every two years and Medicaid provider re-enrollment occurs every five years.

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

**Service Type: Other Service**

**Service Name: Transition Services**

**Provider Category:**

Agency

**Provider Type:**

In Home Care Agency (ORS 443.305)

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

Current and unencumbered nursing license who meets Oregon State Board of Nursing licensure requirements under Oregon Revised Statute 678.010 – 410 and Oregon Administrative Rules, Standards and Scope of Practice for Licensed Nursing.

**Certificate (specify):**

**Other Standard (specify):**

Who has met all rule requirements as an enrolled qualified Medicaid provider under OAR 407-120-0300- thru-0400 and OAR 410-120-1260

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

APD/OHA initially and ongoing

**Frequency of Verification:**

Prior to payment through the MMIS system with nursing license verification occurring every two years and Medicaid provider re-enrollment every five years.

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

**Service Type: Other Service**

**Service Name: Transition Services**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency (ORS 443.005)

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

Current and unencumbered nursing license who meets Oregon State Board of Nursing licensure requirements under Oregon Revised Statute 678.010 – 410 and Oregon Administrative Rules, Standards and Scope of Practice for Licensed Nursing.

**Certificate** (*specify*):

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

Who has met all rule requirements as an enrolled qualified Medicaid provider under OAR 407-120-0300- thru-0400 and OAR 410-120-1260

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

APD/OHA initially and ongoing

**Frequency of Verification:**

Prior to payment through the MMIS system with nursing license verification occurring every two years and Medicaid provider re-enrollment every five years.

## Appendix C: Participant Services

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

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

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

*Check each that applies:*

- As a waiver service defined in Appendix C-3. Do not complete item C-1-c.**
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** Complete item C-1-c.
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** Complete item C-1-c.
- As an administrative activity.** Complete item C-1-c.

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

## Appendix C: Participant Services

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

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

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

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

(a) Positions subject to required criminal history and background investigations. Oregon Revised Statute (ORS) 181.537 and OAR 410-007-0200 through 0370 authorize DHS to conduct reasonable screening to determine whether potential and current providers of waiver services have a history of criminal behavior such that they should not be allowed to provide services to vulnerable people.

•Persons authorized by DHS to receive and process criminal history information and conduct fitness determinations

(b) Scope of investigations. All screenings include information obtained from the Oregon State Police Law Enforcement Data System, but DHS obtains from other sources and states the information necessary to complete the work. For example, DHS will require a national search using fingerprints and the FBI database under several circumstances:

A. The subject individual (SI) has been outside of Oregon:

1. For 60 or more consecutive days during the previous 18 months and the SI is a child care provider or other individual included in OAR.
2. For 60 or more consecutive days during the previous five years for all other SIs.

B. The LEDS check, SI disclosures, or any other criminal records information obtained by the Department indicate there may be criminal records outside of Oregon.

C. The SI has an out-of-state driver license.

D. The Department has reason to question the identity or criminal record of the SI.

E. A fingerprint-based criminal records check is required by federal or state laws or regulations, other Department rules, or by contract with the Department.

F. The SI is an Authorized Designee (AD) or Contact Person (CP).

G. The Department has reason to believe that fingerprints are needed to make a final fitness determination.

DHS authorized designees make final fitness determinations using a weighing test based on law enforcement data provided from the DHS Criminal Records Unit concerning past arrests and convictions as well as mitigating circumstances (e.g. rehabilitation, diversion, time passed since conviction or arrest).

•

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

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

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

a) The Oregon Health Authority authorizes the Department of Human Services Background Checks Unit to act on its behalf in carrying out criminal and abuse checks associated with programs or activities administered by the Authority.

b) Abuse screenings are conducted on Subject Individuals (SIs), including the following-

- An individual who is licensed, certified, registered, or otherwise regulated or authorized for payment by the Department or Authority and who provides care.
- An employee, contractor, temporary worker, or volunteer who provides care or has access to clients, client

information, or client funds within or on behalf of any entity or agency licensed, certified, registered, or otherwise regulated by the Department or Authority.

- Any individual who is paid directly or indirectly with public funds who has or will have contact with recipients of:

- (i) Services within an adult foster home (defined in ORS 29 443.705); or
- (ii) Services within a residential facility (defined in ORS 31 443.400)

- Any individual who works in a facility and provides care or has access to clients, client information, or client funds secured by any residential care or assisted living facility through the services of a personnel services or staffing agency.

- Any individual who works in a facility and provides care, or has access to clients, client information, or client funds secured by any nursing facility through the services of a personnel services or staffing agency.

- an individual who lives in a facility that is licensed, certified, registered, or otherwise regulated by the Department to provide care. The position of this SI includes but is not limited to resident manager, household member, or boarder.

- A homecare worker as defined in ORS 410.600, a personal support worker as defined in ORS 410.600, a personal care services provider, or an independent provider employed by a Department or Authority client who provides care to the client if the Department or Authority helps pay for the services.

- An employee providing care to clients of the Department’s Aging and People with Disabilities (APD) programs who works for an in-home care agency as defined by ORS 443.305 which has a contract with the Department’s APD programs.

- Any individual who is required to complete a background check pursuant to Department or Authority program rules or a contract with the Department or Authority, if the requirement is within the Department or Authority’s statutory authority.

c) All Subject Individuals (SIs) are required to complete a background and abuse screening prior to completing a Provider Enrollment Agreement. Services cannot be authorized, provided or claimed without a completed agreement. Central Office and Office of Licensing and Regulatory Oversight staff review abuse screenings prior to authorizing the issuance of a Medicaid Provider number. A provider cannot be authorized to provide services or claim payment for services until a provider number is issued. A provider cannot be selected as a provider for the service plan unless there is a valid Medicaid provider number. Provider status is verified through the provider enrollment system.

## Appendix C: Participant Services

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

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

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

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

| Facility Type               |  |
|-----------------------------|--|
| Residential Care Facilities |  |
| Assisted Living Facilities  |  |
| Adult Foster Home           |  |

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Please see the waiver-specific Transition Plan in Attachment #2.

**Appendix C: Participant Services**

**C-2: Facility Specifications**

**Facility Type:**

Residential Care Facilities

**Waiver Service(s) Provided in Facility:**

| Waiver Service         | Provided in Facility                |
|------------------------|-------------------------------------|
| Waiver Case Management | <input checked="" type="checkbox"/> |
| Transition Services    | <input checked="" type="checkbox"/> |

**Facility Capacity Limit:**

none

**Scope of Facility Sandards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

| Scope of State Facility Standards                         |                                     |
|---|-------------------------------------|
| Standard  | Topic Addressed                     |
| Admission policies  | <input checked="" type="checkbox"/> |
| Physical environment                                      | <input checked="" type="checkbox"/> |
| Sanitation  | <input checked="" type="checkbox"/> |
| Safety  | <input checked="" type="checkbox"/> |
| Staff : resident ratios                                   | <input checked="" type="checkbox"/> |
| Staff training and qualifications                         | <input checked="" type="checkbox"/> |
| Staff supervision   | <input checked="" type="checkbox"/> |
| Resident rights   | <input checked="" type="checkbox"/> |
| Medication administration                                 | <input checked="" type="checkbox"/> |
| Use of restrictive interventions                          | <input checked="" type="checkbox"/> |
| Incident reporting  | <input checked="" type="checkbox"/> |
| Provision of or arrangement for necessary health services | <input checked="" type="checkbox"/> |

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

**Appendix C: Participant Services**

**C-2: Facility Specifications**

**Facility Type:**

Assisted Living Facilities

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|----------------|----------------------|
|                |                      |

| Waiver Service         | Provided in Facility                |
|------------------------|-------------------------------------|
| Waiver Case Management | <input checked="" type="checkbox"/> |
| Transition Services    | <input checked="" type="checkbox"/> |

**Facility Capacity Limit:**

none

**Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

| Scope of State Facility Standards                         |                                     |
|---|-------------------------------------|
| Standard  | Topic Addressed                     |
| Admission policies  | <input checked="" type="checkbox"/> |
| Physical environment                                      | <input checked="" type="checkbox"/> |
| Sanitation  | <input checked="" type="checkbox"/> |
| Safety  | <input checked="" type="checkbox"/> |
| Staff : resident ratios                                   | <input type="checkbox"/>            |
| Staff training and qualifications                         | <input checked="" type="checkbox"/> |
| Staff supervision   | <input checked="" type="checkbox"/> |
| Resident rights   | <input checked="" type="checkbox"/> |
| Medication administration                                 | <input checked="" type="checkbox"/> |
| Use of restrictive interventions                          | <input checked="" type="checkbox"/> |
| Incident reporting  | <input checked="" type="checkbox"/> |
| Provision of or arrangement for necessary health services | <input checked="" type="checkbox"/> |

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

OAR Chapter 411 Division 054 requires the Assisted Living Facility to ““have qualified staff sufficient in number to meet the 24-hour scheduled and unscheduled needs of each resident and respond to emergency situations””. Overall staffing ratios have not been prescribed for Assisted Living Facilities because residents are typically independent in many areas, with needs varying from site to site, and so the minimum number of staff required to meet resident needs at all sites is not predictable. If the facility is not meeting the needs of the residents, either by failing to provide scheduled services or to respond to emergencies, DHS determines staffing to be inadequate.

DHS is made aware of issues that might lead to this determination primarily through:

- 1) Case manager monitoring of individual service plan implementation
- 2) Licensor observations and other data collected during licensing reviews
- 3) Reports made to protective service agencies, the Governor's Advocacy Office and the Office of the Long-Term Care Ombudsman
- 4) 1915 Waiver QA staff activities and interviews

## Appendix C: Participant Services

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### C-2: Facility Specifications

**Facility Type:**

Adult Foster Home

**Waiver Service(s) Provided in Facility:**

| Waiver Service         | Provided in Facility                |
|------------------------|-------------------------------------|
| Waiver Case Management | <input checked="" type="checkbox"/> |
| Transition Services    | <input checked="" type="checkbox"/> |

**Facility Capacity Limit:**

5 individuals: unrelated by blood or marriage to foster provider; elderly or have disabilities; and receive care.

**Scope of Facility Sandards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

| Scope of State Facility Standards                         |                                     |
|---|-------------------------------------|
| Standard  | Topic Addressed                     |
| Admission policies  | <input checked="" type="checkbox"/> |
| Physical environment                                      | <input checked="" type="checkbox"/> |
| Sanitation  | <input checked="" type="checkbox"/> |
| Safety  | <input checked="" type="checkbox"/> |
| Staff : resident ratios                                   | <input checked="" type="checkbox"/> |
| Staff training and qualifications                         | <input checked="" type="checkbox"/> |
| Staff supervision   | <input checked="" type="checkbox"/> |
| Resident rights   | <input checked="" type="checkbox"/> |
| Medication administration                                 | <input checked="" type="checkbox"/> |
| Use of restrictive interventions                          | <input checked="" type="checkbox"/> |
| Incident reporting  | <input checked="" type="checkbox"/> |
| Provision of or arrangement for necessary health services | <input checked="" type="checkbox"/> |

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

**Appendix C: Participant Services**

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

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

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

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

- Self-directed**
- Agency-operated**

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

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

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

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

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

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

- Other policy.**

Specify:

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

Provider enrollment for case managers is restricted through the 1915(b)(4) waiver. Qualified case managers must be employees of DHS, a AAA office \*or Oregon Tribe\* authorized under the 1915(b)(4) waiver to provide case management services.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

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

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**PM13: Not Applicable. Providers of services (case managers) under this waiver are not required to be licensed or certified to provide services. Transition services payments go directly to the property owner, property manager, utility provider or vendor of specific household items.\***

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

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

|  |                      |
|--|----------------------|
|  | <input type="text"/> |
|--|----------------------|

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation<br><i>(check each that applies):</i> | Frequency of data collection/generation<br><i>(check each that applies):</i> | Sampling Approach<br><i>(check each that applies):</i>   |
|---|--|--|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                      | <input type="checkbox"/> <b>Weekly</b>                                       | <input type="checkbox"/> <b>100% Review</b>  |
| <input type="checkbox"/> <b>Operating Agency</b>                                      | <input type="checkbox"/> <b>Monthly</b>                                      | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                      | <input type="checkbox"/> <b>Quarterly</b>                                    | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>   |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             | <input type="checkbox"/> <b>Annually</b>                                     | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>  |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                     | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs. |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially   |  |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

|   |  |  |
|---|--|--|
| <input type="checkbox"/> Sub-State Entity                                 | <input type="checkbox"/> Quarterly   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS operated offices. |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> Annually  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>  |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>  |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |  |

**Data Aggregation and Analysis:**

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

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

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

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

**Performance Measure:**

**PM14: Number and percent of newly enrolled non-licensed/non-certified providers who adhere to waiver requirements N: Number of newly enrolled nonlicensed/ non-certified providers who adhere to waiver requirements D: Total number of newly enrolled non-licensed/non-certified providers reviewed**

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

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

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

|   |  |   |
|---|--|---|
|   |  | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:   |

|  |  |                               |
|--|--|-------------------------------|
|  |  | <input type="text" value=""/> |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |                               |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM15: Number and percent of enrolled non-licensed/non-certified providers who adhere to waiver requirements ongoing N: Number of enrolled non-licensed/noncertified providers who adhere to waiver requirements ongoing D: Total number of enrolled non-licensed/non-certified providers reviewed**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

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

|  |   |   |
|--|---|---|
|  |   | Describe Group:<br><input type="text"/>                                   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |
|  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation<br><i>(check each that applies):</i> | Frequency of data collection/generation<br><i>(check each that applies):</i> | Sampling Approach<br><i>(check each that applies):</i>  |
|---|--|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                      | <input type="checkbox"/> <b>Weekly</b>                                       | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>                                      | <input type="checkbox"/> <b>Monthly</b>                                      | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                      | <input type="checkbox"/> <b>Quarterly</b>                                    | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             | <input type="checkbox"/> <b>Annually</b>                                     | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                     | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially   |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation<br><i>(check each that applies):</i> | Frequency of data collection/generation<br><i>(check each that applies):</i> | Sampling Approach<br><i>(check each that applies):</i>  |
|---|--|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                      | <input type="checkbox"/> <b>Weekly</b>                                       | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>                                      | <input type="checkbox"/> <b>Monthly</b>                                      | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                      | <input type="checkbox"/> <b>Quarterly</b>                                    | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             | <input type="checkbox"/> <b>Annually</b>                                     | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                     | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>   |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially   |   |

**Data Aggregation and Analysis:**

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

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

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

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

**Performance Measure:**

**PM16: Not applicable. Service providers (case managers) under this waiver have no training requirements. Transition services payments go directly to the property owner, property manager, utility provider or vendor of specific household items.\***

**Data Source (Select one):**

**Training verification records**

If 'Other' is selected, specify:

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

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>  |
|--|---|--|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>  |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br>95%/5%/50%<br>of all DHS- |

|   |  |   |
|---|--|---|
|   |  | operated offices  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/> |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Aggregation and Analysis:**

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

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

Data and reports gathered and created by DHS staff during quality reviews are reviewed and analyzed on a continuous and ongoing basis by designated OHA staff, including the OHA liaison to DHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Designated staff within OHA will review a representative sample of individual files case managed by DHS-operated field offices using a 95%/5%/50% method. For AAAs \*and Oregon Tribes\*, OHA will review a 10% sample of individual files reviewed by DHS during DHS' quality assurance reviews. Upon completion of OHA's analysis and review of DHS' quality assurance data and reports and its own quality assurance file reviews, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document DHS and OHA remediation efforts.

The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and DHS. 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.

The 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.

DHS staff address individual problems with designated OHA staff on an ongoing basis and during regularly scheduled meetings. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving 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 designated OHA staff, the OHA liaison, and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Joint Policy and Operations Steering Committee outlined above, thus informing executive management of OHA and DHS.

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

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

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. Because DHS is monitoring the performance of its contractors (AAA, \*Oregon Tribes\* and service providers) and OHA is monitoring the performance of its operating agency (DHS) and reviewing DHS' monitoring of its contractors, the timelines for corrective action and remediation taken by each agency differ.

Non-compliance will be determined by any performance measure that falls below 86% accuracy. 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)

OHA timelines for remediation:

Corrective Action Plans: Within 30 days of OHA's identification of need for plan of correction, DHS must submit a plan of correction.

Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 30 days of OHA's approval of DHS'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.

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

- No**
- Yes**

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

**Appendix C: Participant Services**

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**C-3: Waiver Services Specifications**

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

**Appendix C: Participant Services**

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

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

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

- Applicable** - The State imposes additional limits on the amount of waiver services.

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

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

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

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

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

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

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

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

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

Please refer to Attachment #2.

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

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

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

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

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

*Specify qualifications:*

- Social Worker

*Specify qualifications:*

- Other

*Specify the individuals and their qualifications:*

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

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

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

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

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

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

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

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

- (a) Supports and information made available to the individual (and/or family or legal representative, as appropriate):

At intake, \* case managers inform individuals (and/or family or legal representative, as appropriate) of all types of public assistance and services, including State plan services. Case managers provide information and assistance to individuals to understand the range of long-term care services available and to assist the individual to select options that meet the individual's needs. Additional supports and information include person-centered planning and how it is applied, the range and scope of individual choices and options, the process for changing the person-centered service plan, grievance and appeals process, individual rights, risks and responsibilities of self-direction, free choice of providers and service delivery models, reassessment and review schedules, defining goals, needs and preferences, identifying and accessing services, supports and resources, development of risk management agreements, and

recognizing and reporting critical events, including abuse investigations.

Case managers usually provide this information through discussions with individuals but also direct individuals to web resources and printed materials. Examples of web resources include-

-Network of Care (<http://oregon.networkofcare.org/index2.cfm?productid=1&stateid=43>)

-Oregon Consumer Guide to Assisted Living Facilities and Residential Care Facilities and A Guide to Oregon Adult Foster Homes <https://adrcforegon.org/consite/explore-in-a-facility.php>

-Oregon Home Care Worker Registry <https://or-hcc.org/#main>

Case managers may also print and provide this material. Local \* offices also offer their own material on selecting a long-term care option or on local resources.

The case manager meets with the individual again to conduct an initial level of care, eliciting expression of needs, values, preference and goals. Case managers will inform the individual of available options and assist the individual through the development of a service plan based on this assessment. Case managers will review and update this service plan with the individual no less than annually and when changes in the individual care needs require a change in service.

(b) Participant's authority to determine who is included in the process:

The individual or legal representative ultimately decides who may or may not be included in plan development discussions and contribute to the individual's service plan. Participants have the right to have anyone they choose present at any assessment. \* Case managers will assist the individual in selecting and notifying other participants in the assessment and planning process. DHS also assists the process by issuing electronic notification 45 days in advance of the due date for annual LOC re-assessment and review of the service plan so that there is time to notify and prepare other participants.

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

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

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

\* Case managers have the responsibility for assessing the individual's level of care and developing a service plan in accordance with the individual's choice of services to be provided. The case manager must address all of the met or unmet needs of the participant through the assessment and provide the participant and service provider(s) with a copy of the service plan for signature by all parties for the authorized services. The case manager will consult with service providers to review and verify the appropriate services are being offered and performed.

DHS relies on the \* electronic case management system and its electronic tool for collecting, storing and summarizing service recipient information for service plan development.

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

Case managers meet with each individual (and family or legal representative, as appropriate) at a schedule that will complete eligibility determination and an initial service plan within 45 days of request for services. The case manager contacts the individual within appropriate time frames to ensure there is no interruption of services. The individual then determines the time and location, as well as identifies the people that the individual wants present at the service planning meeting.

Case managers will meet again with the individual (and family or legal representative, as appropriate) at least

annually to review the service plan. Other persons, as requested by the individual (or legal representative), may contribute to the assessment and development of this plan as well. If the individual chooses, service providers may also be included in both the assessment of needs and the plan development.

All individuals who receive home and community-based services must have an individualized service plan developed annually and updated as needed. Each plan includes the type of service to be provided, the authority under which the service is provided, the amount, frequency and duration of each service, the type of provider to furnish each service and the person responsible for carrying out the service. 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 waiver services. The service plan may be developed shortly thereafter if the participant needs more time to consider service options or research available options as necessary. In addition, plans are flexible and change to address emerging participant needs and preferences.

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

\* Case managers conduct an assessment using the CAPS tool, which prompts the case manager to have 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. Discussion also includes psycho-social elements and the availability of natural supports to assist in meeting needs. CAPS also includes optional resources for assessing participant abilities such as the Mini-Mental Status Exam for cognition and the Timed Up & Go test for mobility. Case managers must inquire and identify risks such as environmental hazards that may jeopardize safety or health. For participants living at home or in some foster homes, their own or family home, case managers gather information about emergency plans in the event of a natural disaster.

If health concerns come to the case manager's attention through observation or discussion, the case manager assists the individual to access health services or necessary medical supplies. Case managers may also refer participants for Long-term Care Community Nursing Services (CNS), including delegation of some nursing tasks and teaching, training and monitoring on a variety of health-related topics. When a participant resides in a community-based care facility, the case manager will meet with the participant, review the facility service plan and meet with facility staff to gain information about participant service needs.

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

\* Case managers inform participants/legal representatives about service options at intake and when the individual is transitioning from a nursing facility. Participants/legal representatives sign a form to document choice of either nursing facility or community-based care and their options of services provided through the waiver and state plan after receiving information about services. \* Case managers give initial applicants for services information about the wide array of options available to them, including services available under the State plan. These choices are explained again by the \* case manager whenever the participant's needs change significantly or when the participant/legal representative is considering changing service options. During plan development, once service needs have been recorded and summarized, service recipient/legal representative and case manager have another opportunity to review the services authorized and delivered and what types of supports are needed to meet the goals in the service plan. (See also D-1.c(a))

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

CAPS has mandatory fields to be completed for ADL needs to determine eligibility. Each ADL and IADL has identified fields for preferences to be recorded regarding the individual's choice on how these services are to be provided. Additional preference may be documents on each screen of the assessment in a comments section. CAPS has a section to records the individual's goals as they relate to quality of life, health, and/or living situation as stated in the participant's own words.

(e) How are waiver and other services coordinated?

The case manager develops the person-centered plan with the participant/legal representative. The case manager discusses services available under waiver and State plan authority and discusses service options with the participant. After the plan is implemented, case managers communicate with participants and providers as needed to

oversee the coordination of services. Case managers directly contact participants and providers by phone, mail, email, or in person within the care setting to address service delivery issues. Plan monitoring is the primary tool for the coordination of services.

Other factors in coordination of services are Oregon Administrative rules and policies that govern what service options may be combined. Some services may not be combined within the same plan as that combination would be considered a duplication of services (such as paying an In-Home Services provider while a participant resides in a facility). DHS Central Office staff provide guidance to case managers through training and policy transmittals as to combination and duplication of services.

DHS Central Office program specialists train case managers to identify existing social networks or natural supports (such as friends and family) and non-Medicaid community programs, services and resources such as Older American Act services) in the service plan. Case managers provide information and/or assist participants to access these services and coordinate these resources with the rest of the plan. Case managers use CAPS to document use of other resources in the service plan to promote the optimal coordination of services.

\* Case managers, coordinate services for individuals who reside in community-based facilities in cooperation with facility staff. The case manager communicates with staff and may participate in care conferences at the facility.

(f) How does the plan development process provide for the assignment of responsibilities to implement and monitor the plan? Case managers conduct plan monitoring to ensure authorized services are being provided. Means of monitoring vary slightly between the two major types of services:

For services provided to a recipient who lives at home, the \* case manager consults with the participant and provider to initiate service delivery, monitor for any change in care needs, and ensure the individual receives necessary supports. The case manager provides a task list for the individual and provider to use to self-monitor type and amount of services authorized. Payment vouchers are signed by the individual and the provider to confirm the monthly service hours provided. The provider returns signed vouchers to the local office for review before payment is authorized.

In residential facilities, a facility service plan is developed with the individual and/or their representative and any persons the individual chooses, and includes all of the services agreed upon in the service plan. The individual and the provider both sign the plan and receive copies of the signed plan. The purpose of the facility service plan is to document the frequency and manner in which the individual's needs will be met. The facility service plan does not supersede the Medicaid waiver service plan and does not authorize payment for any Medicaid services. Facility service plans are reviewed at least annually by the case manager to ensure that the service plan meets the individual's needs and preferences, and reflects the waiver service plan.

Plans for recipients receiving services in their own homes and in adult foster homes may specify monitoring of participant care by a Registered Nurse under contract with DHS if referred by the \* case manager. In addition to RN delegation, the Contract RN may provide health monitoring, consultation with the physician and teaching to the participant and care provider. They may also provide the delegation of nursing tasks to a care provider. The service plan identifies the service provider and the type and frequency of the services authorized by the case manager and agreed to by the individual.

The case manager assigned to the ongoing service case has the responsibility to document in CAPS any risks or potential risks to the individual's health and safety identified in the assessment. The case manager has the responsibility to document monitoring activities related to identified or reported health and safety concerns.

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

Service plans are reassessed at least annually. Service plans are monitored prior to the annual reviews as the individual's needs change, as determined by the case manager during the assessment or upon request of the individual or their representative. The plan is updated at least annually and more frequently with changes in a service recipient's condition or living situation. Sometimes a case manager schedules an earlier reassessment review date when a service recipient's needs, condition or care setting is expected to change. The participant has the right to request changes in provider and living situation and a change in plan will be made as soon as an alternate provider or living situation can be obtained. The case manager updates CAPS with new information and a plan for meeting new or changing needs.

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

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

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

During initial person-centered plan development and subsequent reviews, the individual's Case Manager conducts an assessment using the CAPS tool to review risk factors for health and protective services with the individual, to offer resources to the individual and to plan appropriate safeguards. During the service planning process, the individual and/or their representatives discuss risk factors and back-up plans. The individual's service plan is developed and information regarding risk and back-up plans is incorporated into the person-centered plan. There is a section in the CAPS tool that incorporates identified risks and back-up plans. This information is part of the assessment summary section of the service plan.

Case managers use a risk assessment and monitoring instrument, in conjunction with face-to-face CA/PS evaluations, to evaluate new participants and participants who have just experience significant changes. The instrument will provide new guidelines for contact frequent that are commensurate with the risk assessed.

The instrument will rank the level of risk on a 0-3 scale across ten factors, with 0 being no risk, 1 = low risk, 2 = moderate risk, and 3 = high risk.

Client factors measured:

- 1) Physical functioning;
- 2) Mental and emotional functioning;
- 3) Cognitive functioning;
- 4) Behavioral issues;
- 5) Income/financial issues;
- 6) Safety/cleanliness of residence;
- 7) Service plan meets medical or physical needs;
- 8) Service plan meets mental, emotional, or behavioral needs;
- 9) Adequacy or availability of informal supports;
- 10) Access to needed care or services;
- 11) Power Outage
- 12) Natural Disaster/Extreme Weather

Case manager client contact frequency criteria:

- For clients assessed at high risk (level 3) in three or more factor areas, at least monthly.
- For clients assessed at high risk (level 3) in one or two factor areas, at least quarterly.
- For clients assessed at moderate, low, or no risk (levels 2, 1, or 0) in all factor areas, case managers would have discretion to determine the contact frequency, with at least one additional contact per year.

If the case manager identifies risks to a recipient living at home or in a foster home, a referral to a Registered Nurse under contract with DHS may be made to conduct a nursing assessment. The case manager may authorize follow-up visits. If appropriate, the RN develops a registered nurse plan of care for the participant and provider to follow, may delegate nursing tasks to the provider, and establish a monitoring schedule. Nursing delegation consists of training and observing that the provider is able to perform the task. The registered nurse must continue to monitor the performance of these delegated tasks and such monitoring must conform to Oregon Board of Nursing Standards.

The goals of community nursing care are to: maintain participants at functional level of wellness, minimize risk for participant, maximize the strengths of the participant and the care provider; and promote autonomy and self-management of health care through teaching and monitoring. For recipients living in community-based care facilities, the case manager will work with the facility staff and the facility nurse to address

health concerns.

Vulnerability to Abuse. The case manager may identify other risks and will assess the individual's ability to make an informed decision. In those instances where the individual has the ability to make informed choices, the case manager will discuss alternatives which may mitigate the risk, may offer community resources and will document the individual's ability to make an informed decision. Individuals who demonstrate the lack of ability to understand the consequences of their decisions may be referred for protective services or guardianship services in the absence of legal representatives to assist with decision-making.

Back-up Care Providers: DHS has alternate service providers such as Medicaid contracted in-home care agencies in some regions that an individual can employ on short notice if they cannot locate a Homecare Worker who can meet their needs. There are also other community-based settings such as adult foster care, adult day services, residential care and assisted living for an individual who needs immediate care services if the individual is unable to identify an Homecare Worker to employ. Currently the Oregon Home Care Commission, which maintains the centralized statewide registry of qualified homecare workers, as well as the local \* offices have lists of Homecare Workers enrolled in their specific regional service delivery areas.

For individuals with significant personal care needs, such as those with quadriplegia, case managers often 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 service plan in case the participant's primary provider becomes ill or is suddenly no longer available. Individuals in community-based services always retain the option of transferring from one community-based setting to another or leaving waiver services to receive nursing facility services as their service needs warrant.

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

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

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

Participants are informed of the different waiver services, State plan services, settings and providers during the initial assessment and at each reassessment, or at the request of the individual.

The 1915 (b)(4) waiver restricts access to qualified case management providers to local DHS, AAA offices, \*and Oregon Tribes\*.

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

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

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

OHA is the Single State Medicaid/CHIP agency (SSMA) responsible for the administration of programs funded by Medicaid and CHIP in Oregon. DHS is the Operating Agency responsible for the operation of certain programs under

Medicaid, which includes home and community-based waivers. A copy of the roles and responsibilities of the SSMA

and the Operating Agency outlined in the IAA are available to CMS upon request.

A. DHS is responsible for certain Medicaid/CHIP services as an Organized Health Care Delivery System, providing program administration and as a direct service provider, as outlined in the agreement for services, including

but not limited to:

1. Waiver Case Management (WCM) for all applicable programs administered by DHS;
2. Home and Community-Based Services for programs operated by DHS; and
3. Other services provided in accordance with the Medicaid/CHIP state plan such as personal care services, contracted nursing services, and rehabilitative services, to the extent such services are administered by DHS. DHS staff compile, review and analyze performance data through a variety of file reviews and data reports. Corrective

action/remediation plans are required as areas of improvement are identified. Additional training, technical assistance

and policy updates or clarification are the most commonly used remediation methods. DHS Central Office staff follow-up to ensure appropriate action is taken. A statewide report documenting key performance measures and remediation outcomes is provided to the OHA/DHS Liaison and the Medicaid/CHIP Operations Coordination Committee (MOCSC). The OHA/DHS Liaison and the MOCSC reviews annual reports on key performance measures

to ensure follow-up and compliance. Additionally, OHA staff reviews a percentage of the files reviewed by DHS to demonstrate oversight and assure quality and compliance of the Medicaid programs for which DHS is responsible to administer.

Case Managers who approve the Person-Centered Service Plan are employees of the State, AAAs \*or Oregon Tribes\*. The individual and/or their legal guardian and the Case Manager review and approve the Person-Centered Service Plan. The coordinator writes the plan based on the planning meeting and the individual and/or their legal guardian approves the written plan.

Appendix D performance measures include both a DHS and OHA review of the \*service plan\* to ensure the \*service plans\* are developed and implemented in accordance with the waiver.

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

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

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

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

*Specify the other schedule:*

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

- Medicaid agency
- Operating agency
- Case manager
- Other

*Specify:*

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

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

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

\* Case managers are responsible for the monitoring and implementation of the service plan and participant' health and welfare. The monitoring and follow-up depends on a participant's needs and living situation.

Case managers monitor service plans monthly, and as often as is needed to ensure the appropriate delivery of waiver

and State plan services to the individual. Monitoring includes the review of records and encounter data to ensure that needed services are provided in accordance with the individual's person-centered service plan and that there is no need to update/alter the plan. Monitoring through Contract RN contacts are documented and submitted to the case manager. Case managers use this documentation as a method of monitoring and will remediate any problems that are noted in the documentation.

Monitoring may also include a review of the service plan. This review consists of a determination of the adequacy of the services provided, whether services are provided in accordance with the current service plan, the individual has freely chosen the provider of services, back-up plan effectiveness, health and safety assurances and individual satisfaction with the services provided. This information is documented either in the CAPS tool, or in the case narrative, if a reassessment is not conducted at the time of the monitoring activities.

Remediation may consist of a reassessment of service needs and/or revision of the service plan. Results of monitoring are captured during the 1915 Waiver QA staff case reviews. Data gathered during the 1915 Waiver QA staff reviews are analyzed and remediation/corrective action requests are provided to the local offices for remediation/correction. Statewide remediation is done through training, policy transmittals and other methods of remediation, as required.

The case manager has the responsibility to document any risks or potential risks to individual health and safety identified in the CAPS assessment. The case manager has the responsibility to perform and document monitoring activities related to identified or reported health and safety concerns. Direct in-person contact is made at the request of the individual, representative or provider when there are changes in care needs, the plan is not sufficiently meeting the current care needs or the case manager determines that in-person contact is necessary in the individual's place of residence.

Monitoring also includes monitoring for risk mitigation as described in Appendix D-1-e.

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

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

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

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

### Quality Improvement: Service Plan

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**PM17: Number and percent of waiver participants whose service plans include services and supports that address assessed needs N: Number of waiver participants whose service plans include services and supports that address assessed needs D: Total number of waiver participants reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input type="checkbox"/> State Medicaid Agency   | <input type="checkbox"/> Weekly   | <input type="checkbox"/> 100% Review  |
| <input checked="" type="checkbox"/> Operating Agency   | <input type="checkbox"/> Monthly  | <input checked="" type="checkbox"/> Less than 100% Review   |
| <input type="checkbox"/> Sub-State Entity  | <input type="checkbox"/> Quarterly  | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95%/5%/50% for all AAA offices |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                           | <input type="checkbox"/> Annually   | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>                                    |
|  | <input type="checkbox"/> Continuously and Ongoing                                   | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>  |
|  | <input checked="" type="checkbox"/> Other<br>Specify:<br>Biennially                 |   |

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i> |
|--|---|---|
| <input checked="" type="checkbox"/> State Medicaid Agency                                    | <input type="checkbox"/> Weekly   | <input type="checkbox"/> 100% Review                          |

|   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>Operating Agency</b>                          | <input type="checkbox"/> <b>Monthly</b>                                    | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input type="checkbox"/> <b>Quarterly</b>                                  | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>  |
|--|---|--|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>  |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS operated offices. |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>  |

|  |  |   |
|--|--|---|
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM18: Number and percent of waiver participants whose service plans in which risks and safety factors are assessed N: Number of service plans which risks and safety factors are assessed D: Total number of service plans reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation (check each that applies):</b> | <b>Frequency of data collection/generation (check each that applies):</b> | <b>Sampling Approach (check each that applies):</b>  |
|--|---|--|
| <input type="checkbox"/> <b>State Medicaid Agency</b>                              | <input type="checkbox"/> <b>Weekly</b>                                    | <input type="checkbox"/> <b>100% Review</b>  |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                        | <input type="checkbox"/> <b>Monthly</b>                                   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                   | <input type="checkbox"/> <b>Quarterly</b>                                 | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all AAA offices |
|  |   |  |

|   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/> |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation<br><i>(check each that applies):</i> | Frequency of data collection/generation<br><i>(check each that applies):</i> | Sampling Approach<br><i>(check each that applies):</i>   |
|---|--|--|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                      | <input type="checkbox"/> <b>Weekly</b>                                       | <input type="checkbox"/> <b>100% Review</b>  |
| <input type="checkbox"/> <b>Operating Agency</b>                                      | <input type="checkbox"/> <b>Monthly</b>                                      | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                      | <input type="checkbox"/> <b>Quarterly</b>                                    | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices. |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             | <input type="checkbox"/> <b>Annually</b>                                     | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>  |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                     | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>  |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially   |  |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM19: Number and percent of waiver participants whose service plans address personal goals and preferences N: Number of service plans in which personal goals and preferences are addressed D: Total number of service plans reviewed**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>  |
|--|---|--|
| <input type="checkbox"/> <b>State Medicaid Agency</b>  | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>  |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                  | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all AAA offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>                                    |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>  |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |  |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

|   |  |   |
|---|--|---|
|   |  | Confidence Interval =<br><input type="text"/>   |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>  |
|--|---|--|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>  |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices. |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>  |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>  |

|  |  |  |
|--|--|--|
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |  |
|--|--|--|

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis (check each that applies):  | Frequency of data aggregation and analysis (check each that applies):      |
|---|--|
| <input checked="" type="checkbox"/> State Medicaid Agency   | <input type="checkbox"/> Weekly  |
| <input checked="" type="checkbox"/> Operating Agency  | <input type="checkbox"/> Monthly   |
| <input type="checkbox"/> Sub-State Entity   | <input type="checkbox"/> Quarterly   |
| <input type="checkbox"/> Other<br>Specify:<br><div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input type="checkbox"/> Annually  |
|   | <input type="checkbox"/> Continuously and Ongoing                          |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |

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

**Performance Measures**

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

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

**Performance Measure:**

**PM20: Number and percent of service plans that are completed according to the policies and procedures in the approved waiver N: Number of service plans that are completed according to the policies and procedures in the approved waiver D: Total number of service plans reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|---|--|--|
| <input type="checkbox"/> State Medicaid Agency                              | <input type="checkbox"/> Weekly                                    | <input type="checkbox"/> 100% Review         |

|   |  |  |
|---|--|--|
| <input checked="" type="checkbox"/> <b>Operating Agency</b>               | <input type="checkbox"/> <b>Monthly</b>                                    | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input type="checkbox"/> <b>Quarterly</b>                                  | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all AAA offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>                                    |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>  |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |  |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>  |
|--|---|--|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>  |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = <input type="text"/>              |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>                            |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files |

|  |  |   |
|--|--|---|
|  |  | reviewed by<br>DHS during<br>DHS' review<br>of AAAs |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>   |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |   |

**Data Aggregation and Analysis:**

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

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

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

**Performance Measures**

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

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

**Performance Measure:**

**PM21: Number and percent of waiver participants whose service plan was updated/revised every 12 months N: Number of service plans that were updated/revised every 12 months D: Total number of service plans reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation (check each that applies):</b> | <b>Frequency of data collection/generation (check each that applies):</b> | <b>Sampling Approach (check each that applies):</b>  |
|--|---|--|
| <input type="checkbox"/> <b>State Medicaid Agency</b>                              | <input type="checkbox"/> <b>Weekly</b>                                    | <input type="checkbox"/> <b>100% Review</b>  |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                        | <input type="checkbox"/> <b>Monthly</b>                                   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                   | <input type="checkbox"/> <b>Quarterly</b>                                 | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all AAA offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:                                  | <input type="checkbox"/> <b>Annually</b>                                  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:  |

|  |   |
|--|---|
| <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |
| <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

|  |  |  |
|--|--|--|
|  |  |  |
|--|--|--|

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>  |
|--|---|--|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>  |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices. |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>  |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>  |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |  |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM22: Number and percent of waiver participants whose service plan was revised, as needed to address changing needs N: Number of service plans revised, as needed to address changing needs. D: Total number of service plans reviewed in which revisions were necessary to reflect individuals change in needs.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>  |
|--|---|--|
| <input type="checkbox"/> <b>State Medicaid Agency</b>  | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>  |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                  | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all AAA offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>                                    |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>  |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |  |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

|   |  |   |
|---|--|---|
|   |  | Confidence Interval =<br><input type="text"/>   |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>   |

|  |  |  |
|--|--|--|
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |  |
|--|--|--|

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis (check each that applies):  | Frequency of data aggregation and analysis(check each that applies):       |
|---|--|
| <input checked="" type="checkbox"/> State Medicaid Agency   | <input type="checkbox"/> Weekly  |
| <input checked="" type="checkbox"/> Operating Agency  | <input type="checkbox"/> Monthly   |
| <input type="checkbox"/> Sub-State Entity   | <input type="checkbox"/> Quarterly   |
| <input type="checkbox"/> Other<br>Specify:<br><div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input type="checkbox"/> Annually  |
|   | <input type="checkbox"/> Continuously and Ongoing                          |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |

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

**Performance Measures**

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

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

**Performance Measure:**

**PM23: Number and percent of waiver participants whose services are delivered in the type, scope, amount, duration and frequency in accordance with the service plan. N: Number of waiver participants whose services were delivered in the type, scope, amount, duration and frequency in accordance with the service plan. D: Total number of waiver participants service plans reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies): |
|---|--|--|
|   | <input type="checkbox"/> Weekly                                    | <input type="checkbox"/> 100% Review         |

|   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>State Medicaid Agency</b>                     |  |   |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>               | <input type="checkbox"/> <b>Monthly</b>                                    | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input type="checkbox"/> <b>Quarterly</b>                                  | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for AAA offices. |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>                                 |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>   |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

|  |  |   |
|--|--|---|
|  |  | OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>   |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |   |

**Data Aggregation and Analysis:**

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

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

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

**Performance Measures**

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

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

**Performance Measure:**

**PM24: Number and percent of waiver participants who are offered the choice of institutional care and waiver services N: Number of waiver participants who are offered the choice of institutional care and waiver services D: Total number of waiver participants reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

|  |   |  |
|--|---|--|
| <b>Responsible Party for data collection/generation (check each that applies):</b> | <b>Frequency of data collection/generation (check each that applies):</b> | <b>Sampling Approach (check each that applies):</b>  |
| <input type="checkbox"/> <b>State Medicaid Agency</b>                              | <input type="checkbox"/> <b>Weekly</b>                                    | <input type="checkbox"/> <b>100% Review</b>  |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                        | <input type="checkbox"/> <b>Monthly</b>                                   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                   | <input type="checkbox"/> <b>Quarterly</b>                                 | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all AAA offices |

|   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/> |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% of all DHS-operated offices. |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>   |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |   |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM25: \*Not applicable.** Case management services are provided under authority of a 1915(b)(4) selective contracting waiver that restricts the choice among case management providers to the local offices and tribal authorities. Transition services payments go directly to the property owner, property manager, utility provider or vendor of specific household items.\*

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input type="checkbox"/> State Medicaid Agency   | <input type="checkbox"/> Weekly   | <input type="checkbox"/> 100% Review  |
| <input checked="" type="checkbox"/> Operating Agency   | <input type="checkbox"/> Monthly  | <input checked="" type="checkbox"/> Less than 100% Review   |
| <input type="checkbox"/> Sub-State Entity  | <input type="checkbox"/> Quarterly  | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95%/5%/50% for all AAA offices |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                           | <input type="checkbox"/> Annually   | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>                                    |
|  | <input type="checkbox"/> Continuously and Ongoing                                   | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>  |
|  | <input checked="" type="checkbox"/> Other<br>Specify:<br>Biennially                 |   |

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

|   |  |   |
|---|--|---|
|   |  | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:   |

|  |  |                      |
|--|--|----------------------|
|  |  | <input type="text"/> |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |                      |

**Data Aggregation and Analysis:**

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

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

Data and reports gathered and created by DHS staff during quality reviews are reviewed and analyzed on a continuous and ongoing basis by designated OHA staff, including the OHA liaison to DHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Designated staff within OHA will review a representative sample of individual files case managed by DHS-operated field offices using a 95%/5%/50% method. For AAAs \*and Oregon Tribes\*, OHA will review a 10% sample of individual files reviewed by DHS during DHS’ quality assurance reviews. Upon completion of OHA’s analysis and review of DHS’ quality assurance data and reports and its own quality assurance file reviews, all relevant information from both agencies’ reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document DHS and OHA remediation efforts.

The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and DHS. 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.

The 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.

DHS staff address individual problems with designated OHA staff on an ongoing basis and during regularly scheduled meetings. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving 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 designated OHA staff, the OHA liaison, and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Joint Policy and Operations Steering Committee outlined above, thus informing executive management of OHA and DHS.

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

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

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. Because DHS is monitoring the performance of its contractors (AAA, \*Oregon Tribes\* and service providers) and OHA is monitoring the performance of its operating agency (DHS) and reviewing DHS' monitoring of its contractors, the timelines for corrective action and remediation taken by each agency differ.

Non-compliance will be determined by any performance measure that falls below 86% accuracy. 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)

OHA timelines for remediation:

Corrective Action Plans: Within 30 days of OHA's identification of need for plan of correction, DHS must submit a plan of correction.

Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 30 days of OHA's approval of DHS'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.

**ii. Remediation Data Aggregation**

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

| Responsible Party <i>(check each that applies):</i>   | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
|---|--|
| <input checked="" type="checkbox"/> State Medicaid Agency   | <input type="checkbox"/> Weekly  |
| <input checked="" type="checkbox"/> Operating Agency  | <input type="checkbox"/> Monthly   |
| <input type="checkbox"/> Sub-State Entity   | <input type="checkbox"/> Quarterly   |
| <input type="checkbox"/> Other<br>Specify:<br><div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input type="checkbox"/> Annually  |
|   | <input type="checkbox"/> Continuously and Ongoing                            |
|   | <input checked="" type="checkbox"/> Other<br>Specify:<br>Biennially.         |

**c. Timelines**

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

- No
- Yes

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

**Appendix E: Participant Direction of Services**

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

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

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

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

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

**Appendix E: Participant Direction of Services**

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

**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (6 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (7 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (8 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (9 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (10 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (11 of 13)**

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**Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.**

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (12 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant Direction (1 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant-Direction (3 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix F: Participant Rights**

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**Appendix F-1: Opportunity to Request a Fair Hearing**

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice

(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The case manager notifies the individual about the Fair Hearing process during the initial assessment/service planning, at any time a decision notice is issued and at least annually thereafter. As part of the notification of Fair Hearings procedure, the case manager informs the individual that continuation of services must be requested under the time frames specified in OAR 461-025-0310 and 461-25-0311. Individuals must request a hearing within 45 days of receiving the decision notice. Individuals may request a continuation of benefits pending the hearing decision if the request is made within 10 days of the decision notice and/or prior to the effective date of the action proposed in the notice.

The hearing request form informs the participant that the planned action described in the decision notice will take place on the effective date of the decision notice unless continuation of benefits is requested. The form contains a section that allows the participant to request that services continue during the period while the appeal is under consideration. If the participant requests to continue services, they mark the form accordingly. The default is that services do not continue unless requested. An active request is required to continue services.

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

DHS has standardized forms and processes for informing individuals/legal representatives of rights, recording hearing requests, completing pre-hearing summaries, conducting hearings, and notifying individuals/legal representatives of the hearing outcomes. DHS communicates additions or revisions to forms and processes to local \* field offices through formal electronic transmittals.

Individual service recipients and applicants, and their legal representatives, are provided timely written notice (DHS form 540 Notice of Planned Action) of any planned change in services or benefits, including denial, closure or reduction. The notice includes the reason for Dept.'s decision, administrative rules that support the decision and the individual's/legal representative's right to due process through an administrative hearing process.

Individuals/legal representatives who wish to contest the planned action complete and submit an Administrative Hearings Request (SPD form 443) to the local \* office. The local office forwards the Administrative Hearings Request to the DHS Central Hearings Unit where it is assigned to a DHS Hearing Representative. The Hearing Representatives are centralized and not part of any local office that determines benefits, services, or eligibility. The Hearing Representative reviews the notice sent to the participant to confirm adequacy and accuracy. If the Notice of Planned Action is insufficient or incorrect, the Hearing Representative contacts the local office to correct the Notice of Planned Action, which may or may not result in restoration of benefits until a corrected notice is provided to the participant. Individuals maintain the right to a continuation of benefits until a final order is issued. OAR 461-025-0311 details time frames for timely submission of a hearing request if a continuation of benefits is requested until a final order is issued.

The Hearing Representative conducts an informal conference with the individual/legal representative to provide the individual/legal representative the opportunity to questions the planned action and to present additional information if applicable. After the informal conference, one of four actions occur:

- The individual/legal representative voluntarily withdraws the request for hearing;
- DHS withdraws the planned action;
- The planned action is modified (in which case a new notice of planned action is sent to the individual/legal representative and the individual/legal representative once again has appeal rights); or
- The contested case proceeds to hearing before an Administrative Law Judge.

If the individual/legal representative disagrees with the outcome of the contested case hearing before the Administrative Law Judge, the individual/legal representative may ask for a rehearing or reconsideration of the final order. The Individual/legal representative may also file with the Court of Appeals.

DHS Central Office, Field Services, maintains an automated database that tracks each phase of the process and the outcomes(s) for each individual/legal representative who requests an administrative hearing.

## **Appendix F: Participant-Rights**

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## Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**  
 **Yes. The State operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- No. This Appendix does not apply**  
 **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

Anyone may file a grievance/complaint with the Governor's Advocacy Office in the Office of the Director of the Department of Human Services. The local DHS and AAA offices also have the responsibility to resolve any complaints that are brought to them. If the local office is unable to satisfactorily resolve the complaint, they may refer the person to the Governor's Advocacy Office.

The GAO receives and coordinates complaint resolution for clients of all DHS related programs, including waiver participants and the general public. They collect relevant information from the party of interest and forward the request to the appropriate Central Office managers through controlled correspondence for resolution by phone/email. The GAO and the responding management work collaboratively to resolve the issue.

The GAO maintains a statewide database for any and all complaints related to DHS & APD waiver participants.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Individuals are provided with a Rights and Responsibilities form that informs them of their hearing rights and are also given a form (DHS 9001) that provides them information regarding filing a complaint. These forms are provided at initial eligibility/intake and annually thereafter. This form provides the telephone number for the Governor's Advocacy Office (GAO), as well as information showing how to file a discrimination complaint. Complaints that are received at the local office and are resolved prior to becoming a formal complaint are not tracked for data gathering purposes.

Formal complaints or grievances relate to the individual's dissatisfaction with the provision of services or the performance of the local DHS/AAA office or with DHS Central Office. A formal grievance relates to a complaint about the way waiver services are being delivered or complaints about administrative process. Formal complaints or grievances can be received either in writing or verbally through either the local office or central office.

All formal complaints/grievances are tracked by DHS central office.

Informal complaints are complaints that do not rise to the level of dissatisfaction with provision of services, performance, service delivery or administrative process and are not tracked. These complaints are generally tied to personal preferences and are not related to the defined formal complaint/grievance process and are handled locally, usually by the case manager, or case management supervisor. These complaints are not tied to hearable issues or abuse reporting.

The letter of determination is only optional if the individual is satisfied that the complaint has been resolved and states that they do not need a formal written response regarding the disposition of the complaint. The individual is informed by the case manager at the initial assessment and subsequent reassessments, and at the time the complaint is submitted if their complaint is a hearable issue. Written notification, including hearing rights and instructions for requesting a hearing, are provided at any time there is a reduction or termination of services.

If the individual has a complaint about loss of benefits, the individual is informed of their hearing rights and offered assistance with completing the Hearing Request form.

- a. There is no limitation on the types of complaints an individual may file.
- b. The GAO logs the complaints into their tracking system.
- c. The GAO contacts either DHS central office staff or the local DHS or AAA offices to research and help resolve the complaint. DHS is able to get monthly reports on the types of complaints filed, the outcomes and who the complaint involves. DHS tracks those complaints and has recently begun to do a follow-up survey to assure the complaint was addressed satisfactorily.

#### Process and Timelines:

If the participant uses the Client Complaint or Report of Discrimination Form (DHS 0170), the process is as follows:

1. If the local office receives, they must initiate the resolution process. If the GAO receives it, the complaint is entered into the data base, then forwarded to the appropriate branch office or responsible program entity to initiate the resolution process. If it is a report of discrimination, it is screened for either DHS central office investigation or forwarded to USDA Food and Nutrition Services (FNS) Regional Office Civil Rights Investigation if it is food stamp program-related. (FNS conducts investigations independent of DHS.)
2. Within five business days of receiving this complaint form, the participant must be contacted by the local program supervisor.
3. If it is a report of discrimination, the DHS Civil Rights Investigator must contact the participant within 20 business days. The civil rights investigation will be conducted by the DHS Central Office investigator, who will issue a letter of determination within 20 days following completion of investigation. Appropriate federal civil rights office will be notified.
4. Once contacted, an in-person or telephone meeting is to be conducted or scheduled. If the complaint involves a DHS employee, that employee has five business days to respond. Issues of complaint should be clarified and verified during the initial contact.
5. The complainant may involve a formal or informal support person/advocate at the meeting. If the complaint is regarding an employee, that employee may or may not be present in the meeting (i.e. participant does not want employee there or supervisor makes the call on it). The purpose of this meeting is to identify and address the complaint issues and resolution options.
6. Fact finding is conducted before participant contact, during the meeting session and following the meeting. A determination must be based on evidence. This may include interviews with internal and external parties, review of documentation and program policies, analyzing data and evidence gathered, determination of whether or not complaint is substantiated and consideration of the participant's willingness to resolve the complaint.
7. If the complaint is resolved, the local office is to complete the follow up form (DHS 0170A) for distribution to the GAO (mandatory) and the next level manager within five business days of the meeting. A letter of determination to the participant is optional---the decision is made on a case-by-case basis.
8. If the complaint is not resolved, it is referred to the next management level for review and follow-up. The GAO

must be notified and provided documentation of initial meeting discussion and results within five business days of the meeting. Depending on the complaint, disposition of issue and evidence collected will influence the next steps in this process.

9. If the complaint cannot be resolved at the local office and service area levels, a Central Office team will assume reexamination and continuance of complaint process. The participant may pursue the grievance through the Governor's Advocacy Office or the appropriate federal program authority, including the court system.

10. Informal or verbal complaints are expected to be handled and resolved at the lowest level of intervention. If this is resolved locally, the GAO does not need to be notified. If not, the participant may pursue the grievance through the Governor's Advocacy Office, a higher DHS authority, or the appropriate federal program authority.

11. The GAO has two separate data systems---one specific to the Client Complaint or Report of Discrimination Form (DHS 0710) and a second system for direct and informal contacts with the GAO via 1-800 and TTY phones, fax, letter, and e-mail. Contact information, evidence and resolution are recorded electronically and accessible for program reporting, identification of trends, system or operational issues, training needs, region/office/employee specific patterns and best practices.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

**Yes. The State operates a Critical Event or Incident Reporting and Management Process** (complete Items b through e)

**No. This Appendix does not apply** (do not complete Items b through e)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Types of critical events or incidents

DHS requires report of critical incidents for any individual age 65 and older and adults with disabilities when circumstances involve observed or suspected abuse defined in Oregon Administrative Rule OAR Chapter 411 Division 020. Abuse in these rules means actions or failures to act including abandonment, financial exploitation, neglect, physical abuse, emotional or verbal abuse, self-neglect and sexual abuse. DHS requires reporting of an additional group of critical incidents defined as abuse for these individuals who also live in community-based care facilities. These additional abuse definitions are found in (OAR) Chapter 411 Division 050 for Foster Care Homes, OAR Chapter 411 Division 054 for Residential Care Facilities and Assisted Living Facilities and include involuntary seclusion of a resident for convenience of staff or for discipline, corporal punishment, and inappropriate use of restraints.

Appropriate authority

The Department of Human Services (DHS) is responsible for protective services for adults, age 65 and older, and persons with disabilities in Oregon. These responsibilities extend to individuals receiving waiver and State plan services, private pay services, or no supportive services. General authority for adult protective services to older

adults, age 65 and older, and persons with physical disabilities is in ORS 410.020. Authority for investigations of abuse to adults, age 65 and older is provided in Oregon Revised Statutes (ORS) 124.070.

OHA delegates adult protective services to the DHS Office of Adult Abuse Investigation and Prevention (OAAPI). DHS assigns adult protective services responsibilities to local DHS and AAA offices, including taking reports of abuse (critical incidents) and providing the subsequent follow-up through screening, assessment, investigation, and provision of appropriate resources for victim safety. OAAPI oversees Adult Protective Services (APS) and is the appropriate authority at state level for management of critical incidents.

#### Methods of reporting

Local DHS and AAA offices and DHS Central Office accept reports of critical incidents in any communication forms from anyone who wants to report. Most reports are made by telephone with some reporting done by fax, letters, or e-mails. The local offices have specifically trained staff to record and respond to APS critical incident reports. The state office provides a statewide toll-free number to take reports. The state office and local offices offer translators, adaptive telephone technology, and alternative formats for reporting.

Some critical incidents may come to DHS attention through the Long Term Care Ombudsman. The Office of Long Term Care Ombudsman is an independent state agency that serves long term care (including nursing facility, residential care, assisted living and foster home) residents through complaint investigation, resolution and advocacy for improvement in resident care. The Office includes the Governor-appointed Ombudsman, seven full-time staff and a statewide network of volunteers. If the Ombudsman receives a complaint involving abuse it is referred to DHS APS.

The Governor's Advocacy Office (GAO) is another means by which critical incidents may come to the attention of DHS. This office is in the Director's Office and provides a central point of access for anyone have a problem with, or seeking information about, the entire range of DHS services. If the GAO receives a complaint involving DHS services, GAO staff refer the complaint to OAAPI where adult protective services begin if abuse is involved.

#### Individuals required to report critical incidents and events.

Any person can report suspected or observed abuse incidents to DHS including waiver participants, legal representatives and family. Any reporter has immunity for reports made in good faith for elder abuse.

For Residential Care Facilities and Assisted Living Facilities, the administration of the facility is responsible for reporting abuse. All employees who have reasonable cause to believe a resident has suffered abuse are responsible for reporting to appropriate facility personnel or to the Department. This responsibility is stated in OAR Chapter 411 Division 054 for Residential facilities and Assisted Living Facilities. If DHS discovers through licensing survey, Case manager onsite care monitoring, or complaint that a report has not been forwarded, DHS will investigate that circumstance as a rule violation.

ORS 124.060 mandates certain groups of persons to report elder abuse. Abuse mandated to be reported is defined under ORS 124.050 to be physical injury, neglect of care, abandonment, willful infliction of harm, sexual abuse, and financial abuse. ORS 124.050 (9) lists and defines the mandatory reporters to include:

(a) Physician or physician assistant licensed under ORS chapter 677, naturopathic physician or chiropractor, including any intern or resident.

(b) Licensed practical nurse, registered nurse, nurse practitioner, nurse's aide, home health aide or employee of an in-home health service.

(c) Employee of the Department of Human Services or community developmental disabilities program.

(d) Employee of the Oregon Health Authority, local health department or community mental health program.

(e) Peace officer.

(f) Member of the clergy.

- (g) Regulated social worker.
- (h) Physical, speech or occupational therapist.
- (i) Senior center employee.
- (j) Information and referral or outreach worker.
- (k) Licensed professional counselor or licensed marriage and family therapist.
- (L) Member of the Legislative Assembly.
- (m) Firefighter or emergency medical services provider.
- (n) Psychologist.
- (o) Provider of adult foster care or an employee of the provider.
- (p) Audiologist.
- (q) Speech-language pathologist.
- (r) Attorney.
- (s) Dentist.
- (t) Optometrist.
- (u) Chiropractor.
- (v) Personal support worker, as defined by rule adopted by the Home Care Commission.
- (w) Home care worker, as defined in ORS 410.600.

Case managers and Foster Care Home Licensors are mandatory reporters for elderly persons, age 65 or older of critical events or incidents as defined in ORS 124.050. DHS strongly encourages reporting of critical events or incidents for individuals with disabilities under the age of 65.

#### Timeline for Reporting.

DHS expects reports as soon as abuse, neglect or exploitation is observed or suspected. The Abuse Reporting and Investigation Guide for Providers defines immediate reporting as ““The facility must immediately investigate injuries of unknown cause and report those incidents if abuse cannot be ruled out. It is expected that a determination about injuries of unknown cause can be made within 24 hours of the incident and if abuse can not be ruled out, the incident has been reported within that time frame.”” All community-based care providers are required to complete a provider orientation that provides them with this information. Licensors, Supervisors, Managers and Central Office staff use the ROSE (Report of Serious Event) form (SDS 0307) when serious events occur. This form is used for both facility and community incidents and is used to notify law enforcement if applicable. ROSE forms are to be completed upon discovery of abuse that has occurred, when there is imminent and/or serious threat resident health or safety, when law enforcement is involved or when there has been media attention. Adult Foster home providers are mandatory reporters under Oregon Revised Statutes. There is a criminal penalty for failure to report abuse. Assisted Living and Residential Care providers are subject to civil penalties. Licensing rules require facilities to immediately report abuse. Failure to report immediately results in a civil penalty for non-compliance with licensing rules.

The time frames for reporting as determined by DHS are as follows:

- (a) COMMUNITY CASES (Non-facility, elder abuse, and APS).

(A) IMMEDIATELY: Contact 911 when an emergency situation exists. An emergency is a situation in which evidence suggests that a human life is in jeopardy. The individual is in the process of being harmed due to criminal activity, medical emergency, fire, etc., or is a clear and present danger to self or others;

(B) WITHIN TWO HOURS OF RECEIPT OF COMPLAINT:  
Initiate investigation within two hours when the reported victim is identified as being in imminent danger;

(C) BY THE END OF THE NEXT DIVISION WORKING DAY:  
Initiate investigation by the end of the next working day when the individual is identified as being in a hazardous situation that is one that could lead to increased harm or risk; or

(D) WITHIN FIVE DIVISION WORKING DAYS:  
When screening determines that the situation is problematic, one that is chronic or ongoing, or is a general complaint that an immediate response is unlikely to change the reported victim's risk level, an investigation should be initiated within five working days.

- c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

\* Case managers provide education on the rights and responsibilities of individuals at the time a financial or service case is opened. Information is provided to individuals, family members and/or legal representatives on the process for contacting the case manager or local office Adult Protective Service (APS) Unit to report complaints of abuse/neglect. Local DHS and AAA offices have recorded messages to direct the individual calling in to report abuse/neglect to the appropriate number and to call '911' in an emergency.

DHS OAAPI staff train local DHS and AAA APS specialists in abuse and neglect and reporting through four mandatory training modules offered four times a year that include Fundamentals of APS, APS Community Reports, APS Facility Reports and Legal Processes. DHS OAAPI also offers Fundamentals training four times a year to service case managers to provide basic training on the definitions of abuse and guidelines for determining when to refer to APS. In-Home Services providers (Homecare Workers) are trained on abuse and neglect in their orientation conducted by the Oregon Home Care Commission. Homecare workers are given a workers' guide that provides guidance on identifying indicators of abuse and reporting to the local office. All community-based providers are required to complete abuse and reporting requirements training.

DHS is responsible for and distributes brochures each year on Adult Protective Services and Mandatory Reporting that are widely distributed through the state. Brochures are available in translation and alternative format and are posted on the DHS website (<http://www.oregon.gov/DHS/abuse/Pages/index.aspx>). Many local offices have created their own brochures with local resource and contact information.

DHS works closely with partners on many levels to increase public awareness regarding the identification and reporting of abuse of vulnerable Oregonians. DHS, American Association of Retired Persons and the Governor's Commission on Senior Services collaborate on presentations, forums and conferences about abuse and exploitation. Between the local offices, the state office, and advocate groups there are 2-5 trainings a month at different sites in the state. Twice a year, during Older American's month and on Vulnerable Oregonians Day, there are campaigns to educate the public on abuse and exploitation that include presentations, events with the governor or the attorney general, and public service announcements.

DHS advertises a central helpline 1-800-232-3020 for reporting abuse and neglect and rule violations. DHS Office of Licensing and Regulatory Oversight staff this line for abuse and complaint calls involving seniors and people with disabilities. DHS also offers translation and alternative formats for reporting.

In licensed facilities, education about protection from abuse is provided through the Residents' Bill of Rights. Sections of the Bill of Rights address the right to be safe and secure and free from abuse and neglect and improper restraint. The Residents' Bill of Rights must be posted for in a prominent place. Each resident or resident's designated representative is given a copy of the Bill of Rights. Implementation of a Residents' Bill of Rights is

mandated under ORS 443.739 for Adult Foster Homes and OAR Chapter 411 Division 054 for Residential Care Facilities and Assisted Living Facilities.

OAR Chapter 411 Division 050 requires DHS to furnish each adult foster home with a Complaint Notice. This notice must be posted in a conspicuous place and states the procedure for making complaints and has telephone numbers for making complaints to DHS and the Ombudsman.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

DHS Office of Adult Abuse Prevention and Investigation (OAAPI) is the appropriate authority for receiving reports, reviewing, and responding to all the critical events or incidents identified in G-1a.

OAR Chapter 411 Division 020, General Adult Protective Services, details the procedures for receiving reports, investigating, and documenting critical events or incidents. In addition to General Adult Protective Services, there are also specific administrative rules for Community Based Care that govern investigations of reports of critical incidents: Foster Care Homes OAR Chapter 411 Division 050; Residential Care Facilities and Assisted Living Facilities OAR Chapter 411 Division 054 and In-Home Services ORS 124.050 to 124.095 mandates the procedures investigations of reportedly abused older adults. In all cases, the response to critical incidents consists of a standard series of APS activities including screening, triage (response times), intervention, on-site assessment, investigation, and documentation.

•Screening:

Local DHS and AAA offices must have screeners who receive and review reports about critical events or incidents. All reports that involve the possibility of abuse are screened for protective services. Methods of reviewing involve interviewing and assessing information to determine:

- o If the complaint is a critical event or incident that makes the state definitions of abuse (see G-1a);
- o If the reported victim is an older adult, age 65 or older, or a persons with physical disabilities;
- o Triage (response timeline). The response time is 911 for emergencies, immediately for imminent danger, and next working day for other reports of abuse.

If a report is eligible for Adult Protective Services, then the report is referred on to an APS specialist to provide intervention and conduct an investigation. If a report does not meet criteria for protective services or is not within DHS jurisdiction, then the screener must find and refer the reporter to appropriate available resources, such as the Ombudsman's Office, other public service agencies, law enforcement, etc. The APS specialist may also provide consultation to the reporter to facilitate report to other responsible entities.

• Intervention:

If protective services are needed, then the APS specialist and case manager must immediately provide protective services to reduce or remove the harm or threat of harm. The participant has the right to refuse protective services. If the investigator believes a crime has been committed, local law enforcement is contacted. If the investigator believes that Medicaid fraud has occurred, a referral is made to Oregon Department of Justice, Medicaid Fraud unit. If the reported perpetrator is licensed and the investigator believes there is a licensing concern or substantiated abuse, then a report is made to the licensing agency.

•On-site assessment and investigation:

An APS specialist conducts an evidence-based investigation including on-site assessment of the reported victim, witness interviews, and gathering evidence such as facility, medical, and financial records. The waiver participant has the right to decline participation in the investigation. DHS contracts with a PhD forensic nurse to evaluate injuries in complex cases. APS specialists will work with multi-disciplinary teams that include law enforcement or other law enforcement contacts to staff complex, difficult, and unclear incidents that have the potential of going to prosecution. The evidence is analyzed in a finding of fact. Based upon preponderance of the evidence from the finding of fact, a conclusion is determined if wrongdoing is substantiated, not substantiated, or inconclusive.

•Documentation:

A report is written for each investigation including APS specialist observations, a review of documents and records, a summary of all witness statements, a finding of fact, and a conclusion.

The APS specialist has 60 days from the report of the incident to complete the investigation and write the investigation report.

Distribution of investigation report for facility investigations:

For Adult Foster Homes, Residential Care and Assisted Living Facilities, within 60 days of receiving a completed investigation report the DHS Office of Licensing and Regulatory Oversight must examine the investigation report and make a determination if there was abuse or rule violation and appropriate corrective actions. Upon determination of the findings, a public copy of the investigation must be sent to the complainant, waiver participant or their designee, and other parties. A public copy does not have the names of or any identifying information about the waiver participant, complainants, and all witnesses. The complainant and waiver participant has seven days to add information to the report.

Reporting back to reporter and participant for In-home Services investigation. For In-home services, under privacy law, the whole report is confidential. The reporter, when he or she calls, is offered the option of being informed about the outcome of their report. If abuse was substantiated, then the reporter can be informed that appropriate steps were taken. If abuse was not substantiated, the reporter can only be informed that it was not substantiated. The waiver participant may have a copy of the report upon request; for all the other parties identifying information must be redacted.

Per Oregon Administrative Rule, waiver participants in Adult Foster Homes, Residential Care Facilities and Assisted Living Facilities are notified upon determination of findings, which could be any time up to 60 days from the reported incident. Waiver participants living in their own homes may request findings, which could be any time up to 120 days from the reported incident.

Training for receiving reports and follow-up for investigation:

The DHS OAAPI provides a two-day training to APS screeners on how to screen reports of critical incidents. The training is offered 3-4 times a year.

Adult Protective Service Program Coordinators of the DHS OAAPI conduct a series of trainings that APS specialists must complete. If required, DHS can access a DHS maintained computerized record to confirm these trainings have been completed by APS specialists.

- o “Fundamentals of Adult Protective Services” covers the basic information on policy and procedures and the practice of APS. The first day is open to case managers.

- o Facility Adult Protective Services goes into depth on conducting facility investigations with emphasis on investigative skill development and the corrective action process.

- o Community Protective Services goes into depth on conducting investigation in private homes (In-home Services participants) and assessment of capacity with emphasis on investigative, assessment, and intervention skill development

- o Legal and Court Procedures is an advanced course for testifying in court when critical incidents are referred for prosecution and advocating for participants with the legal and court system.

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DHS OAAPI develops operations and policy for APS and manages the statewide critical incident management and critical incident data systems. DHS OAAPI oversees compliance with state and federal laws and DHS policy and procedures for both the local offices and providers. To maintain quality and assure standardization through the state, DHS trains the APS specialists, provides information technology, and conducts reviews of investigations, and gathers and analyzes APS and corrective actions data.

Facility Oversight and corrective actions:

Within 60 days of a report of abuse involving a licensed facility, local DHS and AAA offices send a completed investigation report to the DHS OAAPI and the Office of Licensing and Regulatory Oversight (OLRO) to be individually reviewed. OAAPI makes the final determination of abuse and/or neglect, whereas OLRO reviews for potential rule violation and determines appropriateness of corrective actions or sanctions in accordance with the Administrative Rules. Actions could range from a warning letter, conditions put on the license, civil penalties, or revocation of the license.

A public copy of the investigation report is sent to the complaint, waiver participant or their designees, and other parties for review and they have seven days to add information.

For systemic problems identified (e.g. many serious incidents reported for a facility, investigators encounter unreported or additional incidents in the course of an investigation) in the Residential Care and Assisted Living Facilities, a referral is made to a Client Care Monitoring Unit (CCMU) and a survey team is dispatched to survey all health and safety issues and compliance with licensing rules. The facility then is required to complete a corrective action plan to remedy any violations.

Local DHS and AAA foster home licensors are contacted with investigation results and follow-up may include re-inspection or development of an additional corrective action plan.

There are specific administrative rules for Community Based Care that govern oversight of reports about and correction actions for critical incidents: Adult Foster Homes OAR Chapter 411 Division 050; Residential Care Facilities and Assisted Living Facilities OAR Chapter 411 Division 054.

In-home Services oversight of critical incident reports:

For In-Home Services, the managers in the local DHS or AAA offices supervise reporting of and response to critical incidents. If there is a complaint or question about the investigation report, then the DHS OAAPI reviews the complaint about the report. The local office is then asked to resolve the complaint or question in compliance to law and policy.

Additional oversight for both facilities and In-home Services is provided in response to complaints received by DHS Administration and the Governor's Advocacy Office about DHS responses to reports of critical incidents that were not resolved to the satisfaction of the person bringing the complaint. The Office of Licensing and Quality of Care conducts a review and, on the basis of this review, DHS Administration responds to complainant and, if necessary, requires local DHS or AAA office to correct errors in policy or procedure.

System-wide operation of data systems:

DHS provides and mandates that the local office use a standardized secure incident reporting forms for documenting investigations. The reports are filed electronically into Oregon Access 723C (community APS reports) and web-based 723 (facilities).

The local offices narrate documentation and also fill out fields in the 723 incident report system, for each investigation. The data from the fields in the reports go into an DHS central database. In addition, the DHS OAAPI assigns incident categories for tracking purposes based on review of investigation records and corrective actions. The information gathered from these forms and encoding include types of incidents, participant characteristics, gender and age of participant, providers/facilities, conclusions, outcomes to waiver participants, and corrective actions. Also captured are time-lines on when the report was made, when responded to, completion of investigation and documentation, when public copies were sent to participant and other parties, and completion of correction actions.

The data is compiled and analyzed in the central data base and data reports generated that are made available to the state office through a desktop application. Reports can be generated by many factors, including by individual, individual characteristics, providers, local office, category of critical incident, results of investigation, timeliness of investigation report completion, etc. The data reports are updated on a daily basis. Internally, DHS uses the data reports to evaluate if investigation, oversight and data systems involved in incident management assure the health and safety of service recipients. Reports are used by operations and policy analysts in DHS Central Office to review quality of response to critical incidents at all levels, gauge quality of care by providers, and guide policy to prevent recurrence.

Examples of how reports are used to provide protections for participants and quality control:

- o Corrective actions in the state office can examine the history of corrective actions taken in response to critical incidents for any licensed facility to see if there is pattern that needs attention.
- o Quarterly, facility reports are sent to local office and state managers about timeliness of completion of investigation reports.
- o The State office can examine reports of open and closed cases for In-home services investigations. Hard copies of reports of open and closed cases are made to the DHS Director and the State APS manager several times a year.
- o Quarterly, reports are sent to local offices about investigation findings and conclusions, including corrective actions affecting participants in facilities.
- o State APS Operations and Policy Analysts refer to the data reports on a regular basis to identify trends, changes in served populations, and means to improve system ability to prevent and respond to abuse, e.g. increase staff education and training, provider training, improve information system technology.

DHS prepares yearly reports of critical incidents in Oregon involving adults age 65 and older and adults with disabilities by, at minimum, living situation, participant characteristics, abuse reporter, relationship of perpetrator to victim, type of abuse or critical incident. DHS Office of Licensing and Quality of Care staff analyze this data by region, facility type, type of abuse to identify trends and patterns for follow-up with provider training, corrective action or policy revision. OAAPI also compares the DHS data with that of the Long-Term Care Ombudsman complaint reports as means of validating and further analyzing trends.

DHS staff compile, review and analyze performance data through field office reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to local offices as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. Central office staff follow-up with local offices to ensure appropriate action is taken. A statewide report documenting key performance measures and remediation outcomes is provided to the Medicaid/CHIP Operations Coordination Committee (MOCSC). The MOCSC reviews annual reports on key performance measures to ensure follow-up and compliance.

The MOCSC will review statewide reports that includes statistics, performance measures, and follow-up activities for critical incidents for all populations served under the waiver, including licensing, adult protective services,. Where additional information or clarification is needed, the MOCSC will ask DHS to provide it. The MOCSC will have access all supporting databases, such as that those of the OAAPI, OLRO and the DHS 1915 Waiver QA staff.

A report regarding Adult Protective Services performance is made to the Oregon legislature every two years.

## Appendix G: Participant Safeguards

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

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

**The State does not permit or prohibits the use of restraints**

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

Improper use of restraints or the seclusion of residents is brought to the Department's attention by various means.

1. A complaint may be reported directly to the Long-term Care Ombudsman's Office and they would notify DHS.
2. Mandatory reporters may report abuse or suspected abuse directly to DHS. Examples include, but are not limited to, physicians, nurses, emergency responders, case managers, nurse consultants, home health nurses).
3. Non-mandatory reporters such as residents (victims or non-victims), occupants of the home, resident family members or other resident representatives, visitors or non-care providers such as repair or maintenance

personnel).

4. The Licenser may observe or identify improper use of restraints or seclusion during a routine licensing inspection.

\* Case managers are responsible for monitoring the service plans in all CBC settings to ensure the services provided adequately meet the individual's care needs. If they observe any use of restrictive interventions, they report it to APS. Community Nurses also monitor for the use of restrictive interventions in Adult Foster Homes. Case managers and Community Nurses are mandatory reports of abuse. Case Managers are required to make quarterly monitoring visits. Part of the monitoring of the service plan is the assurance of health and safety, which includes observing for the use of restrictive interventions. Community Nurses are authorized for visits, as needed, and will observe for the use of restrictive interventions.

In addition, licensors make periodic visits to facilities and report any observed or suspected use of restrictive interventions to local APS specialists. If a local DHS/AAA licenser or Client Care Monitoring Unit licenser observes that a CBC setting has repeat rules violations, potential for harm or actual harm, the licenser reports the provider to DHS OLRO. Sanctions will be applied to the CBC setting if there are findings of improper use of restrictive interventions. These sanctions may include a range of penalties, from civil penalties, up to and including, revocation of license.

DHS is responsible for oversight of the improper use of restraints. DHS staff compile, review and analyze performance data through field office reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to local offices as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. Central office staff follow-up with local offices and licensors to ensure appropriate action is taken. A statewide report documenting performance measures and remediation outcomes is provided to the Medicaid/CHIP Operations Coordination Committee (MOCSC). The MOCSC reviews annual reports on performance measures to ensure follow-up and compliance.

Data are analyzed using the data gathered during the field office reviews, electronic file reviews and data reports. These data are analyzed using different software packages such as PASW Statistics, Microsoft Access and Microsoft Excel. The data can be sorted and categorized to emphasize trends and patterns that would require corrective action or show areas of training need or policy clarification. The data analysis provides information on performance on a statewide, regional, or local office level.

- The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

## Appendix G: Participant Safeguards

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

- b. Use of Restrictive Interventions.** *(Select one):*

**The State does not permit or prohibits the use of restrictive interventions**

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

Improper use of restraints or the seclusion of residents is brought to the Department's attention by various means.

1. A complaint may be reported directly to the Long-term Care Ombudsman's Office and they would notify DHS.
2. Mandatory reporters may report abuse or suspected abuse directly to DHS. Examples include, but are not limited to, physicians, nurses, emergency responders, case managers, nurse consultants, home health nurses).
3. Non-mandatory reporters such as residents (victims or non-victims), occupants of the home, resident family members or other resident representatives, visitors or non-care providers such as repair or maintenance personnel).
4. The Licensor may observe or identify improper use of restraints or seclusion during a routine licensing inspection.

\* Case managers are responsible for monitoring the service plans in all CBC settings to ensure the services provided adequately meet the individual's care needs. If they observe any use of restrictive interventions, they report it to APS. Community Nurses also monitor for the use of restrictive interventions in Adult Foster Homes. Case managers and Community Nurses are mandatory reports of abuse. Case Managers are required to make quarterly monitoring visits. Part of the monitoring of the service plan is the assurance of health and safety, which includes observing for the use of restrictive interventions. Community Nurses are authorized for visits, as needed, and will observe for the use of restrictive interventions.

In addition, licensors make periodic visits to facilities and report any observed or suspected use of restrictive interventions to local APS specialists. If a local DHS/AAA licensor or Client Care Monitoring Unit licensor observes that a CBC setting has repeat rules violations, potential for harm or actual harm, the licensor reports the provider to DHS OLRO. Sanctions will be applied to the CBC setting if there are findings of improper use of restrictive interventions. These sanctions may include a range of penalties, from civil penalties, up to and including, revocation of license.

DHS is responsible for oversight of the improper use of restraints. DHS staff compile, review and analyze performance data through field office reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to local offices as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. Central office staff follow-up with local offices and licensors to ensure appropriate action is taken. A statewide report documenting performance measures and remediation outcomes is provided to the Medicaid/CHIP Operations Coordination Committee (MOCSC). The MOCSC reviews annual reports on performance measures to ensure follow-up and compliance.

Data are analyzed using the data gathered during the field office reviews, electronic file reviews and data reports. These data are analyzed using different software packages such as PASW Statistics, Microsoft Access and Microsoft Excel. The data can be sorted and categorized to emphasize trends and patterns that would require corrective action or show areas of training need or policy clarification. The data analysis provides information on performance on a statewide, regional, or local office level.

**The use of restrictive interventions is permitted during the course of the delivery of waiver services**  
Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

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

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

**The State does not permit or prohibits the use of seclusion**

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

Improper use of restraints or the seclusion of residents is brought to the Department's attention by various means.

1. A complaint may be reported directly to the Long-term Care Ombudsman's Office and they would notify DHS.
2. Mandatory reporters may report abuse or suspected abuse directly to DHS. Examples include, but are not limited to, physicians, nurses, emergency responders, case managers, nurse consultants, home health nurses).
3. Non-mandatory reporters such as residents (victims or non-victims), occupants of the home, resident family members or other resident representatives, visitors or non-care providers such as repair or maintenance personnel).
4. The Licensors may observe or identify improper use of restraints or seclusion during a routine licensing inspection.

\* Case managers are responsible for monitoring the service plans in all CBC settings to ensure the services provided adequately meet the individual's care needs. If they observe any use of restrictive interventions, they report it to APS. Community Nurses also monitor for the use of restrictive interventions in Adult Foster Homes. Case managers and Community Nurses are mandatory reports of abuse. Case Managers are required to make quarterly monitoring visits. Part of the monitoring of the service plan is the assurance of health and safety, which includes observing for the use of restrictive interventions. Community Nurses are authorized for visits, as needed, and will observe for the use of restrictive interventions.

In addition, licensors make periodic visits to facilities and report any observed or suspected use of restrictive interventions to local APS specialists. If a local DHS/AAA licensor or Client Care Monitoring Unit licensor observes that a CBC setting has repeat rules violations, potential for harm or actual harm, the licensor reports the provider to DHS OLRO. Sanctions will be applied to the CBC setting if there are findings of improper use of restrictive interventions. These sanctions may include a range of penalties, from civil penalties, up to and including, revocation of license.

DHS is responsible for oversight of the improper use of restraints. DHS staff compile, review and analyze performance data through field office reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to local offices as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. Central office staff follow-up with local offices and licensors to ensure appropriate action is taken. A statewide report documenting performance measures and remediation outcomes is provided to the Medicaid/CHIP Operations Coordination Committee (MOCSC). The MOCSC reviews annual reports on performance measures to ensure follow-up and compliance.

Data are analyzed using the data gathered during the field office reviews, electronic file reviews and data reports. These data are analyzed using different software packages such as PASW Statistics, Microsoft Access and Microsoft Excel. The data can be sorted and categorized to emphasize trends and patterns that would

require corrective action or show areas of training need or policy clarification. The data analysis provides information on performance on a statewide, regional, or local office level.

- The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.
- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
- Yes. This Appendix applies** (complete the remaining items)

**b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Entity with ongoing responsibility for monitoring participant medication regimens:

The Client Care Monitoring Unit (CCMU) of the DHS OLRO is responsible for monitoring the administration of medications in Residential Care Facilities (RCF) and Assisted Living Facilities (ALF). Local DHS or AAA offices are responsible for onsite licensing and monitoring Adult Foster Homes.

Methods for conducting monitoring:

RCFs and ALFs: CCMU staff interview facility staff administering medications regarding: performance of the task from pour or setup through pass; knowledge of when and which PRN medication to give; procedure to be followed when the resident refuses to take a medication; the system for securing and accounting for controlled substances. The surveyors observe the medication room and spot check for expired medications in the refrigerator and the temperature of the refrigerator and whether it is locked or in a locked room. They check the accuracy of glucometers. They interview residents if there are questionable issues involving a resident's medications. They observe staff pouring medications and passing medications. They observe insulin, inhalers or other routes in addition to oral medications. They then reconcile the pour or pass with the medical record. (Published survey process guidelines are available on request.)

The facility is required to have a safe medication and treatment administration system that has been approved by a pharmacist consultant, registered nurse or physician. Every ninety days a registered pharmacist or registered nurse must review all medications and treatments administered by the facility to residents. The

facility must document their follow-up to the recommendations made by the reviewer.

The monitoring should detect if staff is following the correct protocols for medication administration or not for example any discrepancies between physician orders and the MAR's, nursing delegation has been completed appropriately, resident specific parameters for PRN psychoactive medications are in place and being followed.

Caregivers administering medications for residents receiving medications are required to know the specific reasons for use of the psychoactive medication, the side effects of the medication(s) and when to contact a health professional regarding the side effects. Medications given p.r.n. that are given to treat a resident's behavior must have specific written parameters and used only after non-pharmacological interventions have been tried with ineffective results. Effects of the medication must be documented. All caregivers must have knowledge of non-pharmacological interventions.

Adult Foster Homes:

As part of the annual licensure, the local DHS or AAA office's foster home licensing staff review all resident's medication records and compare them to the physicians' orders, to the medications themselves and the medication labels. They also review the documentation, the PRN charting and the charting of over-the-counter (OTC) medication administration in respect to DHS Adult Foster Home rules. Local DHS and AAA office adult foster home licensors review safety, storage and dispensing accuracy of medications and monitor for medication errors.

Frequency of monitoring:

RCF and ALF: Onsite licensing reviews are conducted every 24 months. If systemic issues are identified as part of abuse follow-up by APS, then CCMU conducts an early full survey of the facility.

The monitoring detects if staff is following the correct protocols for medication administration or not. For example any discrepancies between physician orders and the MAR's, nursing delegation has been completed appropriately, resident specific parameters for PRN psychoactive medications are in place and being followed.

Caregivers administering medications for residents receiving medications are required to know the specific reasons for use of the psychoactive medication, the side effects of the medication(s) and when to contact a health professional regarding the side effects. Medications given PRN that are given to treat a resident's behavior must have specific written parameters and used only after non-pharmacological interventions have been tried with ineffective results. Effects of the medication must be documented. All caregivers must have knowledge of non-pharmacological interventions.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Methods used to ensure participant medications are managed appropriately:

ALFs and RCFs: A 10% sample of medical records is reviewed during the survey process by CCMU. A survey of the facility's residents is prepared by the facility prior to the survey. If a pattern of high use of psychoactive medications or medication errors is found, their 10% sample will be derived from those residents.

Adult Foster Homes: As part of their annual licensure, the local DHS/AAA offices' foster home licensors review all residents' medication records and compare to physician's orders, to the medications themselves and their labels. They also review documentation and PRN charting and OTC administration in respect to DHS Adult Foster Home rules. DHS/AAA office adult foster home licensors review safety and storage of medications, and accuracy of dispensing, and monitor for medication errors.

Identification of potentially harmful practices:

RCFs and ALFs: Inappropriate storage, administration errors, etc. are noted in the survey by CCMU. Surveyors also observe medication administration (pouring and passing of medication) and interview the passers.

Adult Foster Homes: DHS/AAA office's adult foster home licensors review safety and storage of medications, accuracy of dispensing, and monitor for medication errors.

Methods for following up on potentially harmful practices: In all facilities any rule violations are reviewed with the facility at the time of the exit interview. Rule violations will be managed according to administrative rules.

Civil penalties:

License Condition- This is an involuntary action that is taken when the facility has shown a consistent pattern of non-compliance and there has been harm to residents or potential for severe harm. A condition may require the hiring of a nurse or other type consultant, restriction of admissions, etc.

Non-renewal, denial, suspension or revocation when DHS finds there has been substantial failure to comply with rules including, failure to comply with applicable ordinances and rules relating to safety from fire, failing to implement a plan of correction, failure to disclose or provides incorrect information on the licensing application, imminent danger to health or safety of residents, abandonment of facility operation, loss of physical possession of the premise, loss of operational control of the facility or appointment of receiver, trustee, or other fiduciary court order.

Temporary Manager—action may be taken in cases where the licensee's unwillingness or inability to comply with rules, the imminent insolvency of the facility, the revocation or suspension of license or the Divisions determination that the licensee will cease operations without adequate arrangements for relocation of residents.

Adult Foster Homes are reviewed annually during the licensing review. A registered pharmacist or registered nurse must review all medications and treatments administered by the Residential Care Facilities and Assisted Living Facilities to a resident at least every ninety days. The facility must provide documentation related to the recommendations made by the reviewer. Any findings that would result in a licensing violation are reported to the CCMU by the entity responsible for reviewing the medication records every ninety days.

Long-term Care Ombudsman staff are in the building several times per year visiting residents. If they observe questionable practices, then they will contact licensing staff or CCMU. They may also report concerns to protective services. Case managers conduct reviews on clients and are in facilities numerous times per year. They too contact licensing staff as to any concerns they may have. In addition adult protective services workers may also in conducting complaint investigations. If the complaint investigation reveals numerous or severe problems, Central Office is notified and corrective action may be implemented or surveyors may conduct a survey before the 24 month interval.

DHS staff compile, review and analyze performance data through field office reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to local offices as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. Central office staff follow-up with local offices to ensure appropriate action is taken. A statewide report documenting performance measures and remediation outcomes is provided to the Medicaid/CHIP Operations Coordination Committee (MOCSC). The MOCSC reviews annual reports on performance measures to ensure follow-up and compliance.

## **Appendix G: Participant Safeguards**

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

#### **c. Medication Administration by Waiver Providers**

**i. Provider Administration of Medications.** *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*  
**Do not complete the rest of this section**

- ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**iii. Medication Error Reporting.** *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**  
*Complete the following three items:*

(a) Specify State agency (or agencies) to which errors are reported:

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

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

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

## Appendix G: Participant Safeguards

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### Quality Improvement: Health and Welfare

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

**a. Methods for Discovery: Health and Welfare**

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**PM26: Number and percent of waiver participants and/or guardians who are informed about the ways to identify and report abuse, neglect and exploitation N: Number of waiver participants and/or guardians who are informed about the ways in which to identify and report abuse, neglect and exploitation D: Total number of wavier participants reviewed**

Data Source (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input type="checkbox"/> State Medicaid Agency   | <input type="checkbox"/> Weekly   | <input type="checkbox"/> 100% Review  |
| <input checked="" type="checkbox"/> Operating Agency   | <input type="checkbox"/> Monthly  | <input checked="" type="checkbox"/> Less than 100% Review   |
| <input type="checkbox"/> Sub-State Entity  | <input type="checkbox"/> Quarterly  | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95%/5%/50% for all AAA offices |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                           | <input type="checkbox"/> Annually   | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>                                    |
|  | <input type="checkbox"/> Continuously and Ongoing                                   | <input type="checkbox"/> Other<br>Specify:  |

|  |  |                      |
|--|--|----------------------|
|  |  | <input type="text"/> |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |                      |

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

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |   |

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

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i> |
|--|---|---|
|  | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>                   |

|   |  |  |
|---|--|--|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>          |  |  |
| <input type="checkbox"/> <b>Operating Agency</b>                          | <input type="checkbox"/> <b>Monthly</b>                                    | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input type="checkbox"/> <b>Quarterly</b>                                  | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices. |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>  |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>  |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |  |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM27: Number and percent of unexpected or suspicious deaths that are followed up with according to policy N: Number of incidents of unexpected or suspicious deaths that are investigated appropriately (timely and according to policies and procedures) D: Total number of individuals where an unexpected or suspicious death occurs**

**Data Source** (Select one):

**Mortality reviews**

If 'Other' is selected, specify:

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

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

|   |   |   |
|---|---|---|
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                       | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/> |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             |
|   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |   |

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**

**PM28: Number and percent of initial incidents reports that were filed appropriately (timely and according to policies and procedures) N: Number of**

**incident reports completed appropriately (timely and according to policies and procedures) D: Total number of files reviewed which contained initial incident reports**

Data Source (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation<br><i>(check each that applies):</i> | Frequency of data collection/generation<br><i>(check each that applies):</i> | Sampling Approach<br><i>(check each that applies):</i>  |
|---|--|---|
| <input type="checkbox"/> State Medicaid Agency  | <input type="checkbox"/> Weekly  | <input type="checkbox"/> 100% Review  |
| <input checked="" type="checkbox"/> Operating Agency                                  | <input type="checkbox"/> Monthly   | <input checked="" type="checkbox"/> Less than 100% Review   |
| <input type="checkbox"/> Sub-State Entity   | <input type="checkbox"/> Quarterly   | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95%/5%/50% for all AAA offices |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> Annually  | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>                                    |
|   | <input type="checkbox"/> Continuously and Ongoing                            | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>  |
|   | <input checked="" type="checkbox"/> Other<br>Specify:<br>Biennially          |   |

Data Source (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

|   |  |   |
|---|--|---|
|   |  |   |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

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

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% of all DHS-operated offices. |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>   |
|  | <input checked="" type="checkbox"/> <b>Other</b>                                    |   |

|  |                        |  |
|--|------------------------|--|
|  | Specify:<br>Biennially |  |
|--|------------------------|--|

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM29: Number and percent of investigations that were conducted appropriately according to Oregon Administrative Rule 411-020 N: Number of abuse investigations that were conducted in accordance with Oregon Administrative Rule 411-020 D: Total number of files reviewed in which investigation was conducted.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies):                           | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies):  |
|---|--|---|
| <input type="checkbox"/> State Medicaid Agency  | <input type="checkbox"/> Weekly                                    | <input type="checkbox"/> 100% Review  |
| <input checked="" type="checkbox"/> Operating Agency  | <input type="checkbox"/> Monthly                                   | <input checked="" type="checkbox"/> Less than 100% Review   |
| <input type="checkbox"/> Sub-State Entity   | <input type="checkbox"/> Quarterly                                 | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95%/5%/50% for all AAA offices |
| <input type="checkbox"/> Other<br>Specify:<br><input style="width: 100%; height: 20px;" type="text"/> | <input type="checkbox"/> Annually                                  | <input type="checkbox"/> Stratified<br>Describe Group:  |

|  |  |   |
|--|--|---|
|  |  | <input type="checkbox"/>  |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = <input type="text"/>   |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

|  |  |  |
|--|--|--|
|  |  |  |
|--|--|--|

| Responsible Party for data collection/generation<br><i>(check each that applies):</i> | Frequency of data collection/generation<br><i>(check each that applies):</i> | Sampling Approach<br><i>(check each that applies):</i>  |
|---|--|---|
| <input checked="" type="checkbox"/> State Medicaid Agency                             | <input type="checkbox"/> Weekly  | <input type="checkbox"/> 100% Review  |
| <input type="checkbox"/> Operating Agency   | <input type="checkbox"/> Monthly   | <input checked="" type="checkbox"/> Less than 100% Review   |
| <input type="checkbox"/> Sub-State Entity   | <input type="checkbox"/> Quarterly   | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95%/5%/50% for all DHS-operated offices. |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> Annually  | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>  |
|   | <input type="checkbox"/> Continuously and Ongoing                            | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>  |
|   | <input checked="" type="checkbox"/> Other<br>Specify:<br>Biennially          |   |

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**

**PM30: Number and percent of allegations regarding wrongful restraint and involuntary seclusion where investigations are conducted in accordance with OAR 411-020 N: Number of allegations regarding wrongful restraint and involuntary seclusion where appropriate actions and follow-up occurred D: Total number of files reviewed that included allegations of wrongful restraint and involuntary seclusion.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br>(check each that applies): | <b>Frequency of data collection/generation</b><br>(check each that applies): | <b>Sampling Approach</b><br>(check each that applies):  |
|---|--|---|
| <input type="checkbox"/> State Medicaid Agency  | <input type="checkbox"/> Weekly  | <input type="checkbox"/> 100% Review  |
| <input checked="" type="checkbox"/> Operating Agency                                  | <input type="checkbox"/> Monthly   | <input checked="" type="checkbox"/> Less than 100% Review   |
| <input type="checkbox"/> Sub-State Entity   | <input type="checkbox"/> Quarterly   | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95%/5%/50% for all AAA offices |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> Annually  | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>                                    |
|   | <input type="checkbox"/> Continuously and Ongoing                            | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>  |
|   | <input checked="" type="checkbox"/> Other<br>Specify:<br>Biennially          |   |

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

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |   |

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

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

|   |  |  |
|---|--|--|
|   |  | 95%/5%/50%<br>for all DHS-<br>operated<br>offices.                                       |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe<br>Group:<br><input type="text"/> |
|   | <input type="checkbox"/> <b>Continuously and<br/>Ongoing</b>               | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |  |

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

**Performance Measure:**

**PM31: Number and percent of participants with a risk(s) identified on the risk assessment and monitoring instrument where there is evidence of followup.**  
**N:**Number of participants with risk(s) identified on the risk assessment and monitoring instrument where there is evidence of follow-up. **D:**Total number of participants reviewed with risk(s) identified on the risk assessment and monitoring instrument.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input type="checkbox"/> <b>State Medicaid Agency</b>  | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                  | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% of all AAA offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>                                   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>   |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

|   |  |   |
|---|--|---|
|   |  | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:   |

|  |  |                      |
|--|--|----------------------|
|  |  | <input type="text"/> |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |                      |

**Data Aggregation and Analysis:**

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

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

Data and reports gathered and created by DHS staff during quality reviews are reviewed and analyzed on a continuous and ongoing basis by designated OHA staff, including the OHA liaison to DHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Designated staff within OHA will review a representative sample of individual files case managed by DHS-operated field offices using a 95%/5%/50% method. For AAAs \*and Oregon Tribes\*, OHA will review a 10% sample of individual files reviewed by DHS during DHS' quality assurance reviews. Upon completion of OHA's analysis and review of DHS' quality assurance data and reports and its own quality assurance file reviews, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document DHS and OHA remediation efforts.

The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and DHS. 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.

The 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.

DHS staff address individual problems with designated OHA staff on an ongoing basis and during regularly scheduled meetings. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving 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 designated OHA staff, the OHA liaison, and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Joint Policy and Operations Steering Committee outlined above, thus informing executive management of OHA and DHS.

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

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

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. Because DHS is monitoring the performance of its contractors (AAA, \*Oregon Tribes\* and service providers) and OHA is monitoring the performance of its operating agency (DHS) and reviewing DHS' monitoring of its contractors, the timelines for corrective action and remediation taken by each agency differ.

Non-compliance will be determined by any performance measure that falls below 86% accuracy. 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)

OHA timelines for remediation:

Corrective Action Plans: Within 30 days of OHA's identification of need for plan of correction, DHS must submit a plan of correction.

Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 30 days of OHA's approval of DHS'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.

**ii. Remediation Data Aggregation**

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

| Responsible Party <i>(check each that applies):</i>  | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
|--|--|
| <input checked="" type="checkbox"/> State Medicaid Agency  | <input type="checkbox"/> Weekly  |
| <input checked="" type="checkbox"/> Operating Agency   | <input type="checkbox"/> Monthly   |
| <input type="checkbox"/> Sub-State Entity  | <input type="checkbox"/> Quarterly   |
| <input type="checkbox"/> Other<br>Specify:<br><div style="border: 1px solid black; height: 20px; width: 100%; text-align: right; padding-right: 5px;"> <span style="font-size: small;">↑</span><br/> <span style="font-size: small;">↓</span> </div> | <input checked="" type="checkbox"/> Annually                                 |
|  | <input checked="" type="checkbox"/> Continuously and Ongoing                 |
|  | <input checked="" type="checkbox"/> Other<br>Specify:<br><br>Biennially.     |

**c. Timelines**

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

- No
- Yes

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

↑  
↓

**Appendix H: Quality Improvement Strategy (1 of 2)**

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Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 2)

### H-1: Systems Improvement

#### a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Oregon Health Authority and Department of Human Services will utilize performance measures to evaluate all HCBS waivers (0117, 0375, 0565, 40193, 40194, and 0185) as well as the 1915(k) Community-First Choice option. Continuous system improvement is the basis of the Quality Improvement System (QIS). The QIS will utilize discovery, analysis and remediation activities as the method of ensuring that Home and Community-Based Services provided through the waivers and state plan are monitored and that necessary corrective action processes are in place. The discovery and analysis phase will occur on a two-year cycle for all Home and Community-Based services authorized under Section 1915(c) and 1915(k) authorities. Remediation is an ongoing process that will occur during the discovery phase. Individual remediation will occur when corrective action is needed in any one geographic area or field office. System-wide remediation activities will occur every two years, when required, based on statewide discovery and analysis. Both individual and system-wide remediation activities will require a corrective action plan.

Data and reports gathered and created by DHS 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/\*Oregon Tribes\*), 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. System Improvement Activities**

| Responsible Party <i>(check each that applies):</i>   | Frequency of Monitoring and Analysis <i>(check each that applies):</i> |
|---|--|
| <input checked="" type="checkbox"/> State Medicaid Agency   | <input type="checkbox"/> Weekly  |
| <input checked="" type="checkbox"/> Operating Agency  | <input type="checkbox"/> Monthly                                       |
| <input type="checkbox"/> Sub-State Entity   | <input type="checkbox"/> Quarterly                                     |
| <input type="checkbox"/> Quality Improvement Committee  | <input checked="" type="checkbox"/> Annually                           |
| <input type="checkbox"/> Other<br>Specify:<br><div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input checked="" type="checkbox"/> Other<br>Specify:<br>Biennially    |

**b. System Design Changes**

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Staff from DHS Central Office (CO), APD and AAAs administer all services delivered through the waiver operated by DHS, APD.

APD staff use findings from discovery and remediation activities related to the six assurances and other parameters to establish priorities for system improvement and evaluate the effectiveness of those improvements.

APD staff seek input from participants, families, providers, and other interested parties/groups to find ways to deliver waiver services more effectively and efficiently and move the participant toward outcomes stated

in approved plans of care.

APD staff collect QI information from the performance measures related to the six assurances and other topic areas. They work with participants, families, providers, and others to address both concerns raised and improvement opportunities identified. DHS, Program Integrity staff compile reviews and analyze performance data through a variety of file reviews and data reports. Corrective action/remediation plans are required as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods.

DHS, APD staff follow-up to ensure appropriate action is taken. A statewide report documenting key performance measures and remediation outcomes is provided to the OHA/DHS Liaison, the Quality Assurance Review and Remediation Committee (QARRC), and the Medicaid/CHIP Operations Coordination Committee (MOCSC). The OHA/DHS Liaison, QARRC, and the MOCSC reviews annual reports on key performance measures to ensure follow-up and compliance.

Additionally, designated staff within OHA review a representative sample of individual files case managed by DHS-operated offices using a 95%/5%/50% method, and for AAAs OHA reviews a 10% sample of individual files reviewed by DHS during DHS' quality assurance reviews to demonstrate oversight and assure quality and compliance of the Medicaid programs which DHS is responsible to administer.

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

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

The Quality Improvement System will ensure that all discovery and remediation activities have a process in place to ensure system improvement. The Oregon Health Authority and 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.

DHS and OHA staff re-evaluates the QIS at least once during each waiver renewal period (or more as deemed appropriate) and update the QIS strategies employed. From activities conducted by DHS and OHA staff, QIS reports are created detailing discovery and remediation activities related to the six assurances and other parameters.

These staff and Waiver program representatives bring forth issues, trends, priorities and concerns related to the QIS on both individual and multi-waiver levels. These groups evaluate and make recommendations to amend the QIS, waivers, state plan, OARs and policies as necessary to promote high quality services for waiver participants.

QIS reports are specific to each waiver. While the QIS is global and spans all waivers, separate reports are produced for each specific waiver operated by DHS. Reports will cover the full range of waiver activities measured or assessed (level of care, qualified providers, service plans, participant health and welfare, financial accountability, administrative oversight) to develop recommendations for improvements in performance.

DHS and OHA will provide these statewide reports documenting performance measures and remediation outcomes to the Medicaid Director, QARRC and the MOCSC.

The OHA liaison and the MOCSC will review the reports to ensure follow-up and compliance with recommendations made not only by DHS or CMS staff, the QARRC, stakeholders and advocates, but also those that may have been made by OHA and these entities previously. These reports are in addition to the periodic ongoing reports that are presented to OHA and the MOCSC at regularly scheduled meetings during each year.

DHS staff compiles reviews and analyzes performance data through a variety of file reviews and data reports. Corrective action/remediation plans are required as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods.

DHS, APD Central Office staff follow-up to ensure appropriate action is taken.

Additionally, OHA exercises oversight of Medicaid/CHIP programs by employing designated staff to partner with DHS (OHA/DHS liaison), participating in the QARRC, MOCSC, Steering Committee and other related committees in reviewing and approving DHS reports and documents. On a continuous and ongoing basis, OHA will review DHS quality control processes for Medicaid/CHIP programs managed by DHS to assure proper oversight of central office and field operations. This includes a review of a percentage of files already reviewed by DHS staff and other program oversight activities. The OHA liaison or designee reviews the processes employed and outcomes reported, by DHS in order to ensure prompt and accurate level of care determination, participant access to qualified providers, participant-centered service planning/delivery,

enforcement of safeguards that ensure participant health and safety, and maintenance of financial accountability for all home and community-based waiver service levels.

## Appendix I: Financial Accountability

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### I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

OHA contracts directly with DHS, the Organized Health Care Delivery System (OHCDS) through the IAA. DHS, as an Organized Health Care Delivery System, in accordance with 42 CFR 447.10(b), contracts with or enters into provider enrollment agreements, interagency agreements, grants or other similar arrangements with qualified individuals, entities or units of government to furnish Medicaid/CHIP administrative or programmatic services for which DHS has responsibility. DHS makes payment to providers of these services.

At provider enrollment or renewal, DHS informs providers of their right to contract directly with OHA, the single state Medicaid agency.

OHA will establish direct provider agreements and make payment to any qualified provider who does not choose to contract with DHS as the OHCDS.

DHS reviews the qualifications of provider applicants and assures that waiver participants are free to choose qualified providers in their area. OHA includes oversight of provider qualification measures in their reviews of DHS performance. This includes activities to assure that subcontract providers meet all applicable Medicaid requirements for services delivered.

For the Aging and People with Disabilities Waiver the State does not require independent financial statement audits of Waiver Case Management because it is provided by employees of DHS, the AAAs \*and Oregon Tribes\*.

#### Secretary of State Oregon Audits Division

By statute, the Secretary of State, Oregon Audits Division (OAD) conducts audit work in compliance with Government Auditing Standards developed by the U.S. Government Accountability Office. Standards are developed by and for government auditors to ensure quality work is performed in the public interest. These audit standards contain requirements and guidance to assist auditors in objectively acquiring and evaluating sufficient, appropriate evidence as well as reporting the results.

A primary audit conducted by the OAD annually is the Statewide Single Audit. This audit includes an audit of the State of Oregon's financial statements and the state's internal controls and compliance with federal program requirements. Medicaid provider payments are reviewed as part of this audit. The review is based on federal guidelines, and includes client and provider eligibility to receive Medicaid funding.

The OAD also conducts performance audits of State agencies. These audits provide an objective and systematic examination of evidence to provide an independent assessment of a government organization, program, activity, or function. Like financial audits, the goal of these audits is to provide information to agency directors, the governor, the Legislature and citizens of Oregon to improve public accountability and facilitate decision-making by parties with responsibility for overseeing or initiating corrective action. The issues that performance audits cover vary, but generally address whether agencies are operating economically and efficiently, or whether they are achieving desired results.

In addition, the OAD also conducts information technology audits, including general control reviews, application control reviews, security reviews and system development reviews.

#### DHS/OHA Internal Audit and Consulting

The Internal Audit and Consulting (IAC) unit serves both the Department of Human Services (DHS) and the Oregon

Health Authority (OHA) by identifying and evaluating risks, recommending changes to mitigate risks, and assessing the degree to which programs and processes conform to associated statutes, rules and policies. IAC follows “The International Standards for the Professional Practice of Internal Auditing” (Red Book, issued by the Institute of Internal Auditors).

IAC reports to all levels of agency and division management on the adequacy and effectiveness of the agencies’ system of control and performance in carrying out assigned responsibilities so management can determine if:

- Risks are appropriately identified and managed.
- Programs, plans, and department objectives and goals are achieved.
- Significant financial, managerial and operating information is accurate, reliable, and timely.
- Employees' actions are in compliance with policies, standards, procedures, and applicable laws and regulations.
- Resources are acquired economically, used efficiently, and adequately protected.

IAC, in the performance of audits, is granted access to all necessary activities, records, property, and employees while upholding stringent accountability of safekeeping and confidentiality. The IAC auditors are in positions that have no direct authority over activities being reviewed, thus mitigating conflicts of interest.

The Chief Audit Officer of IAC reports functionally to both the DHS Chief Operating Officer and the OHA Chief Financial Officer, and has necessary access to senior management of both DHS and OHA.

DHS/OHA Internal Audit and Consulting has additional responsibility to:

- Perform internal audits in accordance with applicable auditing standards.
- Make recommendations to management regarding opportunities for improvement as identified by the audits.
- Perform consulting services to assist management in meeting objectives, including but not limited to participation on project teams or advisory services as well as providing training.
- As necessary, assist in investigations of allegations of significant fraudulent activities within the agencies and notify management and the Audit Committee of the results.

The IAC unit facilitates the agencies' (DHS and OHA) annual risk assessment process each year. This assessment is the basis for the annual internal audit work plan. To create each year’s risk assessment summary, IAC leverages existing risk assessments from prior years and engages DHS and OHA management and staff in additional discussions. The risks identified from prior periods are sent to responsible management for review and updates. Based on this review, and additional review by department management, a determination is made of which risks should be prioritized as top risks for audit consideration by the two agencies.

DHS and OHA operate a joint committee, the Joint DHS and OHA Audit Committee (Audit Committee). With the assistance of Internal Audit and Consulting Unit, the Audit Committee develops and approves an annual audit plan. The Audit Committee is comprised of executive management from both agencies and includes external partners. The Audit Committee is a forum to address all internal and external audit issues affecting the two agencies, including the monitoring and disposition of those issues. The Audit Committee guides the functions and sets the priorities of the Internal Audit and Consulting unit within DHS/OHA Shared Services. Committee guidance is compliant with ORS 184.360 and OAR 125-700-0010 through 125-700-0155 and in accordance with the Institute of Internal Auditor’s International Standards for the Professional Practice of Internal Auditing.

OHA, Office of Program Integrity:

Audit staff from OHA's Office of Program Integrity, Provider Audits Unit (PAU), review payment records of Medicaid providers continually and on an ongoing basis utilizing a prioritized risk analysis and either a random sample method or 100% claim review. Staff set audit priorities each year based upon assessed risk analysis. The random sample is done using a stratified random sample method based on the Calvin Paper or other statistically valid methodology. The estimate of overpayment is made utilizing a simple extrapolation with a standard error of the estimated overpayment and the confidence interval estimate of the total overpayment calculated from the data obtained from the sampled line items. The estimate of total overpayment is obtained by calculating the overpayment for each stratum and summing these overall strata.

A government body, an organization or an individual can trigger an audit.

These auditors may conduct desk audits or on-site field audits as determined by the Auditor and PAU management. Auditors may consider other audits of the provider as described in OAR. Provider and Contractor Audits, Appeals and Post-Payment Recoveries are described in OAR 407-120-1505.

The Office of Payment Accuracy and Recovery, Fraud Investigation Unit (FIU), a DHS/OHA Shared Service, and OPI,PAU receive reports of fraud in Medicaid programs and investigates allegations. FIU investigates allegations of consumer fraud. PAU investigates fraud allegations against providers such as billing for services not rendered, intentionally billing in duplicate, billing for higher level of services than was delivered, billing for services provided by unlicensed or otherwise ineligible practitioners, and kickback schemes.

PAU sends fraud referrals to the Medicaid Fraud Control Unit (MFCU) where there is a credible allegation of fraud or an unusually high error rate found in the audit. The MFCU reviews and investigates cases where there is a potential prosecution. In addition, PAU informally consults with the MFCU on other suspected cases of fraud. OPAR maintains a hotline for anyone to report consumer fraud and provider fraud.

Case reviews are conducted by the DHS QA Team and the OHA Review team. These reviews include desk reviews, electronic file reviews and face-to-face contact with waiver participants to determine that services are being provided as agreed. 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. QA teams review the service plan and assessment to determine if the plan meets the needs of the participant. This also documents that case management services were provided. Monthly monitoring and risk monitoring are reviewed in the same manner. The electronic file documents when services were provided. Follow-up face-to-face interviews with participants also provides verification of service provision.

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

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

**a. Methods for Discovery: Financial Accountability Assurance:**

***The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")***

**i. Sub-Assurances:**

- a. Sub-assurance: *The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)***

**Performance Measures**

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

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

**Performance Measure:**

**PM32: Number and percent of claims approved with appropriate plan of care specified in the approved waiver. N: Number of claims approved in accordance with the appropriate plan of care D: Total number of claims approved for files reviewed**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

|  |  |  |
|--|--|--|
|  |  |  |
|--|--|--|

| Responsible Party for data collection/generation<br><i>(check each that applies):</i> | Frequency of data collection/generation<br><i>(check each that applies):</i> | Sampling Approach<br><i>(check each that applies):</i>   |
|---|--|--|
| <input type="checkbox"/> State Medicaid Agency  | <input type="checkbox"/> Weekly  | <input type="checkbox"/> 100% Review   |
| <input checked="" type="checkbox"/> Operating Agency                                  | <input type="checkbox"/> Monthly   | <input checked="" type="checkbox"/> Less than 100% Review  |
| <input type="checkbox"/> Sub-State Entity   | <input type="checkbox"/> Quarterly   | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95%/5%/50% for all AAA offices. |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> Annually  | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>                                     |
|   | <input type="checkbox"/> Continuously and Ongoing                            | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>   |
|   | <input checked="" type="checkbox"/> Other<br>Specify:<br>Biennially          |  |

Data Source (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

|  |  |   |
|--|--|---|
|  |  |   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>   |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |   |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**PM33: Number and percent of waiver billable claims paid as specified in the approved waiver N: Number of claims appropriately coded and paid for in accordance with the reimbursement methodology. D: Total number of claims coded and paid for files reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies):  |
|---|--|---|
| <input type="checkbox"/> State Medicaid Agency                              | <input type="checkbox"/> Weekly                                    | <input type="checkbox"/> 100% Review  |
| <input checked="" type="checkbox"/> Operating Agency                        | <input type="checkbox"/> Monthly                                   | <input checked="" type="checkbox"/> Less than 100% Review   |
| <input type="checkbox"/> Sub-State Entity                                   | <input type="checkbox"/> Quarterly                                 | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95%/5%/50% for all AAA offices |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>          | <input type="checkbox"/> Annually                                  | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>                                    |
|   | <input type="checkbox"/> Continuously and Ongoing                  | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>  |
|   | <input checked="" type="checkbox"/> Other                          |   |

|  |                        |  |
|--|------------------------|--|
|  | Specify:<br>Biennially |  |
|--|------------------------|--|

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

| Responsible Party for data collection/generation<br><i>(check each that applies):</i>           | Frequency of data collection/generation<br><i>(check each that applies):</i> | Sampling Approach<br><i>(check each that applies):</i>  |
|---|--|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                                | <input type="checkbox"/> <b>Weekly</b>                                       | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>  | <input type="checkbox"/> <b>Monthly</b>                                      | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>  | <input type="checkbox"/> <b>Quarterly</b>                                    | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input style="width: 50px;" type="text"/>                                 |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input style="width: 100px;" type="text"/> | <input type="checkbox"/> <b>Annually</b>                                     | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input style="width: 100px;" type="text"/>   |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                     | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially   |   |

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

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

|   |  |  |
|---|--|--|
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input type="checkbox"/> <b>Quarterly</b>                                  | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices. |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>  |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>  |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |  |

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

*themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**PM34: Number and percent of waiver claims approved using appropriate rate methodology specified in the approved waiver. N: Number of approved claims paid using the appropriate rate methodology. D: Total number of claims approved for files reviewed**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>  |
|--|---|--|
| <input type="checkbox"/> <b>State Medicaid Agency</b>  | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>  |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                  | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>   |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all AAA offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>                                    |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>  |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially          |  |

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

|   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input type="checkbox"/> <b>Quarterly</b>                                  | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input type="checkbox"/> <b>Annually</b>                                   | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|   | <input type="checkbox"/> <b>Continuously and Ongoing</b>                   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of AAAs |
|   | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |   |

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>   |
|--|---|---|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                             | <input type="checkbox"/> <b>Weekly</b>  | <input type="checkbox"/> <b>100% Review</b>   |
| <input type="checkbox"/> <b>Operating Agency</b>   | <input type="checkbox"/> <b>Monthly</b>   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>   | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95%/5%/50% for all DHS-operated offices |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input type="checkbox"/> <b>Annually</b>  | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                            | <input type="checkbox"/> <b>Other</b><br>Specify:   |

|  |  |                      |
|--|--|----------------------|
|  |  | <input type="text"/> |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially |                      |

**Data Aggregation and Analysis:**

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

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

Data and reports gathered and created by DHS staff during quality reviews are reviewed and analyzed on a continuous and ongoing basis by designated OHA staff, including the OHA liaison to DHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Designated staff within OHA will review a representative sample of individual files case managed by DHS-operated field offices using a 95%/5%/50% method. For AAAs \*and Oregon Tribes\*, OHA will review a 10% sample of individual files reviewed by DHS during DHS’ quality assurance reviews. Upon completion of OHA’s analysis and review of DHS’ quality assurance data and reports and its own quality assurance file reviews, all relevant information from both agencies’ reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document DHS and OHA remediation efforts.

The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and DHS. 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.

The 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.

DHS staff address individual problems with designated OHA staff on an ongoing basis and during regularly scheduled meetings. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving 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 designated OHA staff, the OHA liaison, and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Joint Policy and Operations Steering Committee outlined above, thus informing executive management of OHA and DHS.

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

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

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. Because DHS is monitoring the performance of its contractors (AAA, \*Oregon Tribes\* and service providers) and OHA is monitoring the performance of its operating agency (DHS) and reviewing DHS' monitoring of its contractors, the timelines for corrective action and remediation taken by each agency differ.

Non-compliance will be determined by any performance measure that falls below 86% accuracy. 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)

OHA timelines for remediation:

Corrective Action Plans: Within 30 days of OHA's identification of need for plan of correction, DHS must submit a plan of correction.

Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 30 days of OHA's approval of DHS'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.

**ii. Remediation Data Aggregation**

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

| <b>Responsible Party</b> <i>(check each that applies):</i>   | <b>Frequency of data aggregation and analysis</b><br><i>(check each that applies):</i> |
|--|--|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>   | <input type="checkbox"/> <b>Weekly</b>   |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>  | <input type="checkbox"/> <b>Monthly</b>  |
| <input type="checkbox"/> <b>Sub-State Entity</b>   | <input type="checkbox"/> <b>Quarterly</b>  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input type="checkbox"/> <b>Annually</b>   |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                               |
|  | <input checked="" type="checkbox"/> <b>Other</b><br>Specify:<br>Biennially.            |

**c. Timelines**

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

- No**
- Yes**

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

**Appendix I: Financial Accountability**

**I-2: Rates, Billing and Claims (1 of 3)**

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The interim monthly Waiver Case Management 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.

The monthly case management rate is published on the Aging and People with Disabilities rate schedule. Participants, providers and the general public may access the rate schedule online at <https://www.oregon.gov/DHS/SENIORS-DISABILITIES/PROVIDERS-PARTNERS/Pages/index.aspx>.

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.

\*Transition services rates for moving and move-in costs are the actual, most cost-effective price for the product or service offered through a competitive bidding process using appropriate vendors. The state based the maximum cost for moving on historical costs associated with transition services funded through the 1915(k) optional benefit. The registered nurses providing training and teaching to natural supports as described in the service definition in Appendix C 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 RNs will request prior-authorization and submit claims for client services utilizing billing codes per instructions in provided by APD. These providers will be paid the same as the Long Term Care Community Nurses defined in the 1915 (k). The rate table is at:

<http://www.dhs.state.or.us/policy/spd/transmit/pt/2017/pt17001.pdf>\*

Opportunities for public comment and input are provided in accordance with 42 CFR 447.205. The public comment and input process is described in Main-6 of this application.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

a) DHS' payment systems accesses the MMIS recipient files for Medicaid eligibility, client service eligibility, case management encounters, and provider subsystems to verify client and provider eligibility prior to releasing payments for services for individuals receiving waiver services. If an individual is not eligible for waiver services on the date the service is received, no payment is authorized.

b) The following describes the process and method of payment utilized by DHS to pay for case management services through a non-MMIS payment system. This description includes the billing process and records retention. Medicaid is the payor of last resort for all services described below.

c) To document expenditures, enrollments and payments, DHS central office will access monthly reports of the service provided, by provider that are generated from the Oregon ACCESS Case Management System.

d) AAA agencies are paid for case management services under a contract with DHS. Case management services provided directly by DHS staff are factored into the salary paid through the state payroll system.

e) An adjustment will be made in the payroll system for the total of all case management services provided by DHS staff that will automatically report to the CMS-64.

f) The monthly total will be submitted for payment through our accounts payable system utilizing payment codes that automatically report to the CMS-64.

\*Transition services - moving and move-in- providers will bill DHS directly through the use of invoices. Invoices will be paid directly through DHS payment systems.

RN billings for teaching and training natural supports will flow directly to the Medicaid Management Information System (MMIS), reported to the State Financial Management Application (SFMA) and paid out of MMIS once the billing has been validated. Payment for validated claims are made directly (electronically) to the provider of service. MMIS is an electronic web based system that manages all aspects of client information, rate authorization, Prior Authorizations, provider claims and billing.

APD has access to MMIS reports and DHS accounting records, by individual client, that will allow tracking and accounting reconciliation of RNs paid Transition Services waiver funds for teaching and training natural supports.\*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

**c. Certifying Public Expenditures** *(select one):*

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

*Select at least one:*

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a) Client eligibility information is contained in Oregon ACCESS and in MMIS. Waiver Case Management claims are entered into the Oregon ACCESS system. Qualifying encounters are pulled out of Oregon ACCESS and matched with eligible individuals when passed through the payment system.

b) The service plan provides authorization for all state plan and waiver services, including the amount and duration. For all waiver services, the case manager authorizes the specific services to be provided in the service plan. The service plan is confirmed through signatures by the individual (or representative) and the Case Manager. DHS and OHA staff review authorized services and provision of services during Quality Improvement Reviews. If a service has been claimed without authorization, the claim will be backed out of both the annual 372 expenditure report and the quarterly CMS-64 report.

C) Validation of service provision is accomplished through Quality Assurance reviews. During the course of reviews, DHS and OHA quality management staff review a statistically valid sample of cases to review the authorized service plan with the receipt of authorized services. This is accomplished through direct contact with the individuals who receive services and reviewing case notes/narrative for case management contacts.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments to waiver case management providers are made through either the State of Oregon payroll system or through the designated Area Agency on Aging approved payroll system. Case managers are employees of either State or local government.

Payroll audit processes follow the audit standards for State or local government payroll systems. Payroll reports and RDMS reports are utilized to determine the proportion of payroll attributable to waiver case management. Oregon currently reports these activities as administrative activities on the CMS-64. The same process will be used to claim these activities as waiver expenditures on the CMS-64.

\*Payments for transition services- moving and move in costs- are made directly through DHS payment systems. Providers submit an invoice for services rendered. The invoice is prior authorized to ensure the participant is eligible on the date of service and the service is included in the service plan. DHS payment systems maintain an electronic record of all paid claims that is subject to audit on request. All clean claims are submitted for the appropriate FFP as waiver expenditures on the CMS-64.

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

- b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

OHA contracts directly with DHS, the Organized Health Care Delivery System (OHCDS) through the IAA. DHS, as an Organized Health Care Delivery System, in accordance with 42 CFR 447.10(b), contracts with or enters into provider enrollment agreements, interagency agreements, grants or other similar arrangements with qualified individuals, entities or units of government to furnish Medicaid/CHIP administrative or programmatic services for which DHS has responsibility. DHS makes payment to providers of these services.

At provider enrollment or renewal, DHS informs providers of their right to contract directly with OHA, the single state Medicaid agency.

OHA will establish direct provider agreements and make payment to any qualified provider who does not choose to contract with DHS as the OHCDS.

DHS reviews the qualifications of provider applicants and assures that waiver participants are free to choose qualified providers in their area. OHA includes oversight of provider qualification measures in their reviews of DHS performance. This includes activities to assure that subcontract providers meet all applicable Medicaid requirements for services delivered.

DHS requires providers to maintain relevant service record information for a minimum of three years, per federal regulatory requirements. Service providers are required to permit authorized representatives of DHS to review these records for audit purposes. Providers are required to meet the requirements stated in OAR 411.351.0000 et seq.

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

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### I-3: Payment (4 of 7)

**d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

DHS local office and, Area Agencies on Aging provide case management services. DHS offices are State government providers and AAA offices are local government providers, either through counties or through regional Councils of Government.

## Appendix I: Financial Accountability

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### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

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### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

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v

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

#### g. Additional Payment Arrangements

##### i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

^  
v

##### ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

OHA contracts directly with DHS, the Organized Health Care Delivery System (OHCDS) through the IAA. DHS, as an Organized Health Care Delivery System, in accordance with 42 CFR 447.10(b), contracts with or enters into provider enrollment agreements, inter-agency agreements, grants or other similar arrangements with qualified individuals, entities or units of government to furnish Medicaid/CHIP administrative or programmatic services for which DHS has responsibility. DHS makes payment to providers of these services.

At provider enrollment or renewal, DHS informs providers of their right to contract directly with OHA, the single state Medicaid agency.

OHA will establish direct provider agreements and make payment to any qualified provider who does not choose to contract with DHS as the OHCDS.

DHS reviews the qualifications of provider applicants and assures that waiver participants are free to choose qualified providers in their area. OHA includes oversight of provider qualification measures in their reviews of DHS performance. This includes activities to assure that subcontract providers meet all applicable Medicaid requirements for services delivered.

DHS requires providers to maintain relevant service record information for a minimum of three years, per federal regulatory requirements. Service providers are required to permit authorized representatives

of DHS to review these records for audit purposes. Providers are required to meet the requirements stated in OAR 411.351.0000 et seq.

Additionally, audit staff from the Department of Human Services and the Secretary of State's Office periodically review payment records of Department providers based on their applicable state statutes and administrative rules to ensure provider billing integrity. Staff from both agencies set audit priorities each year based upon assessed risk analysis. Audit methods include on-site review as well as independent data analysis.

DHS auditors periodically evaluate provider financial condition and contractual compliance, review fiscal audits performed on contractors by other agencies, provide consultation to the Secretary of State's Division of Audits programs, and evaluate provider financial system issues for compliance with federal and state standards. DHS determines the frequency of audits and also requests random records monthly.

A government body, an organization or an individual can trigger an audit. DHS auditors perform both desk reviews and on-site examinations of providers' records, facilities and operations, and other information Internal Programs. DHS auditors provide timely, accurate, independent and objective information about DHS operations and programs. An internal audit committee made up of representatives from each DHS administrative unit works closely with the Audit Unit to ensure comprehensive audit coverage. The committee approves an annual audit plan of risk-based and required cyclical audits, then meets every two months, updating the plan as needed based on special requests, investigations, legislative inquiry, or other administrative direction. Auditors have complete access to all necessary activities, records, property and employees. The auditors have no direct authority over activities being reviewed. They abide by the Institute of Internal Auditors' Code of Ethics and practices conform to the Standards for the Professional Practice of Internal Auditing, as promulgated by the Institute of Internal Auditors, the American Institute of CPA's (AICPA), the Federal General Accounting Office (GAO) Yellow Book, Institute of Internal Auditors (IIA), and Information Systems Audit and Control Association (ISACA). DHS internal audits fall into two categories: classification and issue-specific.

Priority for audits is set by: Risk analysis, assessing the extent of fiscal, legal, and/or public policy impact for each potential audit subject, with those having the highest level of risk given top priority; and Database analysis, which determines the quantity, magnitude, degree of aberration, and inconsistencies that exist in current application of practices. Audit Unit staff and the audit committee use the audit process to assess functions and control systems and to make recommendations to DHS administration regarding issues such as: economical and efficient use of resources; progress meeting DHS goals and outcomes; reliability and integrity of information; consumer health and safety; compliance with laws, regulations, policies, procedures, and contract terms; safeguarding assets, adequacy of internal controls; sound fiscal practices; effective management systems; and security and controls of information systems.

#### Secretary of State Audits:

The Audits Division is responsible for carrying out the duties of the Secretary of State's Office as the constitutional Auditor of Public Accounts. The Audits Division is the only independent auditing organization in the state with the authority to review programs of agencies in all three branches of state government and other organizations receiving state money. Authority for the responsibilities of the Audits Division is found in sections 297.00 through 297.990 of the Oregon Revised Statutes. Secretary of State auditors review the areas of finance, performance, information technology, and fraud and abuse. Frequency of SOS audits is based on risk assessment and on standards established by nationally-recognized entities including, but not limited to, the GAO and the National Association of State Auditors. Types of audits include: Financial and compliance audits of all components of state government and state-aided institutions. These audits determine whether a state agency has conducted its financial operations properly and has presented its financial statements in accordance with generally accepted accounting principles. Examinations of internal control structures and determine whether state agencies have complied with finance-related legal requirements. At the end of each engagement, the Division prepares an opinion regarding financial statements, reports significant finds, and recommends any necessary improvements.

Financial and compliance audits of the state's annual financial statements:

This audit, the largest audit of public funds in the state and a major engagement of the Division,

complies with the Single Audit Act of 1984 (PL 92-502) which requires such an audit annually as a condition of eligibility for Federal funds:

- Performance audits of the operations and results of state programs determine whether the programs are conducted in an economical and efficient manner;
- Special studies and investigations regarding misuse of state resources or inefficient management practices;
- Requested audits or special studies for counties.

In accordance with statutory provisions and in cooperation with the State Board of Accountancy and the Oregon Society of Certified Public Accountants, the Division: develops the standards for conducting audits of all Oregon municipal corporations; prescribes, revises, and maintains minimum standards for audit reports; and reviews reports, certificates, and procedures for audits and reviews of corporations. The Division evaluates reports of audits or reviews of these municipal corporations and auditor's work papers for compliance with the standards.

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

**iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:***

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching

arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The Oregon State Legislature will appropriate general funds directly to the Department of Human Services for funding the waiver. The Oregon Health Authority will request the Federal Match through the CMS 64 process.

**Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

**Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

*Check each that applies:*

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

**None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

**The following source(s) are used**

*Check each that applies:*

**Health care-related taxes or fees**

- Provider-related donations**
- Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

CBC in 24 hour Residential Facilities: DHS annually determines the amounts providers must collect from participants for room and board. These amounts are publicized through DHS policy transmittal processes and input into the CBC provider payment system (512) as an amount that the participant is responsible for paying. The service rate is the only amount the provider can receive from DHS.

Services to individuals living in their own home: Providers invoice only for hours of service and authorized rates do not include room and board by rule.

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

**a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

*Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)**

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

**Appendix J: Cost Neutrality Demonstration**

**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Nursing Facility**

| Col. 1 | Col. 2   | Col. 3    | Col. 4      | Col. 5   | Col. 6    | Col. 7      | Col. 8                          |
|--------|----------|-----------|-------------|----------|-----------|-------------|---------------------------------|
| Year   | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1      | 941.00   | 9707.45   | 10648.45    | 27585.12 | 2893.07   | 30478.19    | 19829.74                        |
| 2      | 983.04   | 10103.51  | 11086.55    | 30075.63 | 3011.10   | 33086.73    | 22000.18                        |
| 3      | 1013.23  | 10515.73  | 11528.96    | 32791.01 | 3133.96   | 35924.97    | 24396.01                        |
| 4      | 1053.45  | 10944.78  | 11998.23    | 35751.53 | 3261.82   | 39013.35    | 27015.12                        |
| 5      | 1095.28  | 11391.32  | 12486.60    | 38979.35 | 3394.91   | 42374.26    | 29887.66                        |

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (1 of 9)**

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

| Waiver Year | Total Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) |       |
|-------------|---|--|-------|
|             |   | Level of Care:   |       |
|             |   | Nursing Facility   |       |
| Year 1      | 39480   |  | 39480 |
| Year 2      | 42288   |  | 42288 |
| Year 3      | 44648   |  | 44648 |
| Year 4      | 47864   |  | 47864 |

| Waiver Year | Total Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) |       |
|-------------|---|--|-------|
|             |   | Level of Care:   |       |
|             |   | Nursing Facility   |       |
| Year 5      | 51305   |  | 51305 |

## Appendix J: Cost Neutrality Demonstration

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

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average length of stay is calculated by using the number of waiver days calculated on the most recent 372 report, adjusted to the current waiver year, divided by the forecasted number of waiver recipients for each waiver year.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates for \*Waiver Case Management\* for Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Cost allocation for Waiver case management projected from July 1, 2013 through December 31, 2016.

Cost allocation methodology:

The 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 monthly rate (cost per unit).

The average units per user is calculated using the standard of each individual receiving a monthly service and calculating in the average length of stay ( $12 * (278/365) = 9.14$ ).

All costs are inflated annually by 4.08% based on the DRI Inflationary Index.

\*Service costs estimates were developed using substantially similar services offered in the 1915(k) for individuals transitioning from institutions to HCBS or for individuals receiving 1915(k) services. Nursing costs are based on the costs for Long-Term Care Community Nurses authorized under 1915(k) of the State plan. These rates are published at <http://www.dhs.state.or.us/policy/spd/transmit/pt/2017/pt17001.pdf>.\*

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates of Factor D' for each waiver year are included in Item J-1. The basis for these estimates is as follows:

Actual acute care costs for unduplicated waiver participants as reported on the CMS-372 waiver report projected forward. The CMS-372 report for Waiver Year 3 (January 1, 2014 - December 31, 2014) is used to calculate Factor D' for this renewal. The Waiver Year 3 Factor D' amount is projected forward by 4.08% for the final two years of the waiver cycle and the first year of the new waiver cycle to establish the Waiver Year 1 (Jan 1, 2017 - Dec 31, 2017) Factor D' estimate. Factor D' estimates are inflated by 4.08% for the entire waiver cycle based on the DRI Inflationary Index used to rebase and project the Nursing Facility daily rate. The expenditures are post Part D Medicare implementation and reflect the removal of prescribed drugs.

**iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Projected cost per day of Nursing Facility services effective July 1, 2016 through July 1, 2017. Nursing facility daily rates are determined annually as described in OAR 411-070-0442. Inflation used- 4.08% based on the DRI Inflationary Index used to rebase and project the Nursing Facility daily rate.

**iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates of Factor G' for each waiver year are included in Item J-1. The basis for these estimates is as follows:

Actual acute care costs for unduplicated waiver participants as reported on the CMS-372 waiver report projected forward. The Waiver Year 3 Factor G' amount is projected forward by 4.08% for the final two years of the waiver cycle and the first year of the new waiver cycle to establish the Waiver Year 1 (Jan 1, 2017 - Dec 31, 2017) Factor G' estimate. Factor G' estimates are inflated by 4.08% for the entire waiver cycle based on the DRI Inflationary Index used to rebase and project the Nursing Facility daily rate.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

|                        |  |
|------------------------|--|
| Waiver Services        |  |
| Waiver Case Management |  |
| Transition Services    |  |

## Appendix J: Cost Neutrality Demonstration

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

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

| Waiver Service/Component                                  | Capitation               | Unit    | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost  |
|---|--------------------------|---------|---------|---------------------|-----------------|----------------|-------------|
| Waiver Case Management Total:                             |                          |         |         |                     |                 |                | 36535779.00 |
| Waiver Case Management                                    | <input type="checkbox"/> | Monthly | 39480   | 9.14                | 101.25          | 36535779.00    |             |
| <b>GRAND TOTAL:</b>                                       |                          |         |         |                     |                 |                | 37135779.00 |
| Total: Services included in capitation:                   |                          |         |         |                     |                 |                |             |
| Total: Services not included in capitation:               |                          |         |         |                     |                 |                | 37135779.00 |
| <b>Total Estimated Unduplicated Participants:</b>         |                          |         |         |                     |                 |                | 39480       |
| <b>Factor D (Divide total by number of participants):</b> |                          |         |         |                     |                 |                | 941.00      |
| Services included in capitation:                          |                          |         |         |                     |                 |                |             |
| Services not included in capitation:                      |                          |         |         |                     |                 |                | 941.00      |
| <b>Average Length of Stay on the Waiver:</b>              |                          |         |         |                     |                 |                | 278         |

| Waiver Service/Component                                  | Capitation               | Unit       | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost         |
|---|--------------------------|------------|---------|---------------------|-----------------|----------------|--------------------|
| <b>Transition Services Total:</b>                         |                          |            |         |                     |                 |                | <b>600000.00</b>   |
| Teaching and Training Natural Supports - RN               | <input type="checkbox"/> | Hour       | 250     | 10.00               | 60.00           | 150000.00      |                    |
| Transition Services                                       | <input type="checkbox"/> | Transition | 250     | 1.00                | 1800.00         | 450000.00      |                    |
| <b>GRAND TOTAL:</b>                                       |                          |            |         |                     |                 |                | <b>37135779.00</b> |
| Total: Services included in capitation:                   |                          |            |         |                     |                 |                |                    |
| Total: Services not included in capitation:               |                          |            |         |                     |                 |                | 37135779.00        |
| <b>Total Estimated Unduplicated Participants:</b>         |                          |            |         |                     |                 |                | <b>39480</b>       |
| <b>Factor D (Divide total by number of participants):</b> |                          |            |         |                     |                 |                | <b>941.00</b>      |
| Services included in capitation:                          |                          |            |         |                     |                 |                |                    |
| Services not included in capitation:                      |                          |            |         |                     |                 |                | 941.00             |
| Average Length of Stay on the Waiver:                     |                          |            |         |                     |                 |                | 278                |

**Appendix J: Cost Neutrality Demonstration**

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

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

| Waiver Service/Component                                  | Capitation               | Unit       | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost         |
|---|--------------------------|------------|---------|---------------------|-----------------|----------------|--------------------|
| <b>Waiver Case Management Total:</b>                      |                          |            |         |                     |                 |                | <b>40730668.28</b> |
| Waiver Case Management                                    | <input type="checkbox"/> | Monthly    | 42288   | 9.14                | 105.38          | 40730668.28    |                    |
| <b>Transition Services Total:</b>                         |                          |            |         |                     |                 |                | <b>840000.00</b>   |
| Teaching and Training Natural Supports - RN               | <input type="checkbox"/> | Hour       | 350     | 10.00               | 60.00           | 210000.00      |                    |
| Transition Services                                       | <input type="checkbox"/> | Transition | 350     | 1.00                | 1800.00         | 630000.00      |                    |
| <b>GRAND TOTAL:</b>                                       |                          |            |         |                     |                 |                | <b>41570668.28</b> |
| Total: Services included in capitation:                   |                          |            |         |                     |                 |                |                    |
| Total: Services not included in capitation:               |                          |            |         |                     |                 |                | 41570668.28        |
| <b>Total Estimated Unduplicated Participants:</b>         |                          |            |         |                     |                 |                | <b>42288</b>       |
| <b>Factor D (Divide total by number of participants):</b> |                          |            |         |                     |                 |                | <b>983.04</b>      |
| Services included in capitation:                          |                          |            |         |                     |                 |                |                    |
| Services not included in capitation:                      |                          |            |         |                     |                 |                | 983.04             |
| Average Length of Stay on the Waiver:                     |                          |            |         |                     |                 |                | 278                |

**Appendix J: Cost Neutrality Demonstration**

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

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

| Waiver Service/Component                                  | Capitation               | Unit       | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost         |
|---|--------------------------|------------|---------|---------------------|-----------------|----------------|--------------------|
| <b>Waiver Case Management Total:</b>                      |                          |            |         |                     |                 |                | <b>44758512.73</b> |
| Waiver Case Management                                    | <input type="checkbox"/> | Monthly    | 44648   | 9.14                | 109.68          | 44758512.73    |                    |
| <b>Transition Services Total:</b>                         |                          |            |         |                     |                 |                | <b>480000.00</b>   |
| Teaching and Training Natural Supports - RN               | <input type="checkbox"/> | Hour       | 200     | 10.00               | 60.00           | 120000.00      |                    |
| Transition Services                                       | <input type="checkbox"/> | Transition | 200     | 1.00                | 1800.00         | 360000.00      |                    |
| <b>GRAND TOTAL:</b>                                       |                          |            |         |                     |                 |                | <b>45238512.73</b> |
| Total: Services included in capitation:                   |                          |            |         |                     |                 |                |                    |
| Total: Services not included in capitation:               |                          |            |         |                     |                 |                | 45238512.73        |
| <b>Total Estimated Unduplicated Participants:</b>         |                          |            |         |                     |                 |                | <b>44648</b>       |
| <b>Factor D (Divide total by number of participants):</b> |                          |            |         |                     |                 |                | <b>1013.23</b>     |
| Services included in capitation:                          |                          |            |         |                     |                 |                |                    |
| Services not included in capitation:                      |                          |            |         |                     |                 |                | 1013.23            |
| <b>Average Length of Stay on the Waiver:</b>              |                          |            |         |                     |                 |                | <b>278</b>         |

**Appendix J: Cost Neutrality Demonstration**

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

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

| Waiver Service/Component                                  | Capitation               | Unit    | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost         |
|---|--------------------------|---------|---------|---------------------|-----------------|----------------|--------------------|
| <b>Waiver Case Management Total:</b>                      |                          |         |         |                     |                 |                | <b>49942369.75</b> |
| Waiver Case Management                                    | <input type="checkbox"/> | Monthly | 47864   | 9.14                | 114.16          | 49942369.75    |                    |
| <b>GRAND TOTAL:</b>                                       |                          |         |         |                     |                 |                | <b>50422369.75</b> |
| Total: Services included in capitation:                   |                          |         |         |                     |                 |                |                    |
| Total: Services not included in capitation:               |                          |         |         |                     |                 |                | 50422369.75        |
| <b>Total Estimated Unduplicated Participants:</b>         |                          |         |         |                     |                 |                | <b>47864</b>       |
| <b>Factor D (Divide total by number of participants):</b> |                          |         |         |                     |                 |                | <b>1053.45</b>     |
| Services included in capitation:                          |                          |         |         |                     |                 |                |                    |
| Services not included in capitation:                      |                          |         |         |                     |                 |                | 1053.45            |
| <b>Average Length of Stay on the Waiver:</b>              |                          |         |         |                     |                 |                | <b>278</b>         |

| Waiver Service/Component                                  | Capitation               | Unit       | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost         |
|---|--------------------------|------------|---------|---------------------|-----------------|----------------|--------------------|
| <b>Transition Services Total:</b>                         |                          |            |         |                     |                 |                | <b>480000.00</b>   |
| Teaching and Training Natural Supports - RN               | <input type="checkbox"/> | Hour       | 200     | 10.00               | 60.00           | 120000.00      |                    |
| Transition Services                                       | <input type="checkbox"/> | Transition | 200     | 1.00                | 1800.00         | 360000.00      |                    |
| <b>GRAND TOTAL:</b>                                       |                          |            |         |                     |                 |                | <b>50422369.75</b> |
| Total: Services included in capitation:                   |                          |            |         |                     |                 |                |                    |
| Total: Services not included in capitation:               |                          |            |         |                     |                 |                | 50422369.75        |
| <b>Total Estimated Unduplicated Participants:</b>         |                          |            |         |                     |                 |                | <b>47864</b>       |
| <b>Factor D (Divide total by number of participants):</b> |                          |            |         |                     |                 |                | <b>1053.45</b>     |
| Services included in capitation:                          |                          |            |         |                     |                 |                |                    |
| Services not included in capitation:                      |                          |            |         |                     |                 |                | 1053.45            |
| Average Length of Stay on the Waiver:                     |                          |            |         |                     |                 |                | 278                |

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

| Waiver Service/Component                                  | Capitation               | Unit       | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost         |
|---|--------------------------|------------|---------|---------------------|-----------------|----------------|--------------------|
| <b>Waiver Case Management Total:</b>                      |                          |            |         |                     |                 |                | <b>55713300.04</b> |
| Waiver Case Management                                    | <input type="checkbox"/> | Monthly    | 51305   | 9.14                | 118.81          | 55713300.04    |                    |
| <b>Transition Services Total:</b>                         |                          |            |         |                     |                 |                | <b>480000.00</b>   |
| Teaching and Training Natural Supports - RN               | <input type="checkbox"/> | Hour       | 200     | 10.00               | 60.00           | 120000.00      |                    |
| Transition Services                                       | <input type="checkbox"/> | Transition | 200     | 1.00                | 1800.00         | 360000.00      |                    |
| <b>GRAND TOTAL:</b>                                       |                          |            |         |                     |                 |                | <b>56193300.04</b> |
| Total: Services included in capitation:                   |                          |            |         |                     |                 |                |                    |
| Total: Services not included in capitation:               |                          |            |         |                     |                 |                | 56193300.04        |
| <b>Total Estimated Unduplicated Participants:</b>         |                          |            |         |                     |                 |                | <b>51305</b>       |
| <b>Factor D (Divide total by number of participants):</b> |                          |            |         |                     |                 |                | <b>1095.28</b>     |
| Services included in capitation:                          |                          |            |         |                     |                 |                |                    |
| Services not included in capitation:                      |                          |            |         |                     |                 |                | 1095.28            |
| Average Length of Stay on the Waiver:                     |                          |            |         |                     |                 |                | 278                |