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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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:**
ICF/IDD Comprehensive Waiver
C. **Waiver Number:OR.0117**
Original Base Waiver Number: OR.0117.R3
D. **Amendment Number:**
E. **Proposed Effective Date:** *(mm/dd/yy)*
04/22/16
Approved Effective Date of Waiver being Amended: 07/01/13

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
This amendment application is requesting to:

In Appendix B-4 b add 1902(a)(10)(A)(i)(VIII) and 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); and 1931(b) and (d) of the Act eligibility groups.

In Appendix C:
• Add to the Case Management definition to include *additional monitoring as needed which may include the review of records and encounter data to ensure that needed services are provided in accordance with the individual's person-centered service plan.* as well as *Information and assistance in support of participant direction as it pertains to employer authority.* This activity is already reflected in Appendix E-1 (9 of 13) but was not replicated in the Appendix C Waiver Case Management definition.
• Add a new waiver service, Direct Nursing.

In Appendix E - technical adjustments

In Appendix I and waiver years three - five in Appendix J Revise rates for Supported Employment - Individual Employment Support, Job Coaching, Job Development and for Discovery/Career Exploration Services. Also, update projections for Case Management.

Quality Improvement Strategy in Appendix A, B, C, D, G, H, and I - revised Methods for Remediation/Fixing Individual Problems to reflect timelines in current rule. The waiver currently reads Corrective Action Plans: Within 30 days of Department's identification of need for plan of correction, entities reviewed must submit a plan of correction. Revised will read Corrective Action Plans: Within 45 days of Department's identification of need for plan of correction, entities reviewed must submit a plan of correction.

3. Nature of the Amendment

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)
☐ Waiver Application	
☐ Appendix A – Waiver Administration and Operation	
☑ Appendix B – Participant Access and Eligibility	
☑ Appendix C – Participant Services	
☐ Appendix D – Participant Centered Service Planning and Delivery	
☑ Appendix E – Participant Direction of Services	E-1 (1of13)a. E-1 (4 (
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☑ Appendix I – Financial Accountability	
☑ 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:
  Revise Remediation/Fixing Individual Problems sections in appendix A, B, C, D, G, H, and I.

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*):
ICF/IDD Comprehensive 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.0117
Draft ID: OR.004.05.04

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

E. **Proposed Effective Date of Waiver being Amended: 07/01/13**
Approved Effective Date of Waiver being Amended: 07/01/13

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

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

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

○ **Not applicable**

◉ **Applicable**
Check the applicable authority or authorities:

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

☑ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:
The state has submitted a 1915(b)(4) waiver- "Office of Developmental Disability Services Selective Contracting 1915(b)(4) Waiver - Waiver Case Management #OR.10". The state is proposing to limit the

choice of qualified providers of Waiver Case Management services to employees of Community Developmental Disability Programs and the Office of Developmental Disability Services.

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

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☑ **§1915(b)(4) (selective contracting/limit number of providers)**

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

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

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

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

☑ **A program authorized under §1115 of the Act.**

Specify the program:
-1115 Demonstration Waiver - Oregon Health Plan.
-Medicaid State Plan Personal Care.
-Home and Community-Based Attendant Care services authorized under section 1915(k) of the Act.
-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 Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Purpose:
The Oregon Department of Human Services (hereinafter referred to as DHS or the Department) operates Waiver #0117 to provide home and community-based services to individuals with intellectual disabilities or developmental disabilities and promotes and supports individual self-determination, person-centered planning, and shared responsibility/risk for decision-making regarding supports.

Goal and Objective:
DHS endeavors to serve individuals in the least restrictive, most cost-effective community alternatives to ICFs/IID, based on assessed needs, personal preferences and choice.

Service Delivery Methods:
**Services provided to individuals to enhance and achieve independence and to avoid institutionalization through a combination of state plan and waiver services. Waiver and State Plan services may be delivered in a variety of service settings such as an individual's own or family home, substitute homes (e.g. foster homes or group care homes), employment sites or in the community.
Individuals receive supports when the local CDDP has established eligibility. Once eligibility has been established, a representative from the CDDP will work with an individual and their family or legal representatives to assess needs and plan
for access to services.
An Individual Support Plan is established with each individual to identify services provided based upon their health and safety needs, interests, choices and goals as identified by a functional needs assessment. Each plan uses a person-centered planning process. Services are accessed through the local Community Developmental Disabilities Program (CDDP).

Organizational Structure:
The Oregon Health Authority, Division of Medical Assistance Programs, (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 (hereinafter referred to as DHS or the Department) is the Operating Agency responsible for the operation of certain programs under Medicaid, including home and community-based waivers.

OHA and DHS, by written inter agency agreement (IAA), 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.

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

At CMS' direction and with National Quality Enterprise's assistance, the state revised the Quality Improvement System (QIS) and performance measures for its 1915(c) HCBS waivers.

3. Components of the Waiver Request

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

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

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

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

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

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

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

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

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

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan

to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

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

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

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

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

C. **Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-

based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. **Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
Opportunities for public input on service performance and continuing needs are not limited to this waiver renewal process. Request for public input is posted on the DHS website at http://www.oregon.gov/dhs/dhsnews/Pages/news-releases.aspx. Public input is provided during this process, as well as during meetings with program staff and stakeholders prior to submission of any waivers or waiver amendments.

Self-advocates, families, provider organizations and community leaders were instrumental in developing an original vision of community-based alternatives to ICF/IDD services that led to creation of Oregon's waiver service system in the 1980s and continue to partner with the State to improve and enhance community-based services to individuals with I/DD. Consumer-based advisory groups are longstanding partners, as are groups representing providers and local governments, in revisiting the vision and establishing parameters for services. Several service developments and corresponding waiver amendments have had their roots in this public input over a long history with waiver services.

Standing committees such as the Oregon Developmental Disability Council, Oregon Rehabilitation Association and Community Providers Association of Oregon meet regularly to provide comment and input to the Department on quality, reimbursement, and issues that directly affect the population served under the waiver. These committees consist of members the public, including recipients, advocates and service providers. The Home Care Commission is a quasi-governmental agency that meets regularly with recipients, advocates and providers and provides input to the Department on issues that affect recipients of in-home services. Recommendations made by these committees are utilized during development and implementation of any changes to the waiver and services provided to waiver recipients.

Oregon Tribes are notified and provided adequate time to provide input in accordance with Presidential Executive Order 13175. Tribes are notified through a quarterly meeting attended by representatives of all Oregon tribes and liaisons from various departments of OHA and DHS. These meetings provide written notification of any changes to the tribal representatives and allow for verbal and written comments to proposed changes. If tribes request additional information, DHS will provide prior to implementation of any proposed changes.

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

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

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

7. Contact Person(s)

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

Last Name: Coyner

First Name: Lori

Title: Medicaid Director

Agency: Oregon Health Authority

Address: 500 Summer St. NE

Address 2:

City: Salem

State: **Oregon**

Zip: 97301-1079

Phone: (503) 947-2340 **Ext:** ☐ **TTY**

Fax: (503) 947-2341

E-mail:

lori.a.coyner@state.or.us

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

Last Name:

Teninty

First Name:

Lilia

Title:

Director - Office of Developmental Disabilities Services

Agency:

Oregon Department of Human Services

Address:

500 Summer St NE

Address 2:

City:

Salem

State: **Oregon**

Zip:

97301-1064

Phone:

(503) 945-6918 **Ext:** ☐ **TTY**

Fax:

(503) 373-7823

E-mail:

LILIA.TENINTY@.state.or.us

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:

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

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

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

"The State assures that 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."

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

Phase I. Initial Regulatory Assessment (June- 2014 – April 2015)

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; Addictions and Mental Health (AMH), 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 providerowned, 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 a "global scorecard". The scorecard (Appendix B) evaluates rules and regulations related to provider-owned, controlled, or operated settings licensed/certified by APD, AMH 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 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 scorecard is not intended to be the final determination of current individual site compliance or identification of any necessary changes, but it provides an initial snapshot of the status of Oregon's HCBS system. Through this initial assessment, DHS and OHA have found that no immediate changes were necessary to its Oregon Revised Statues (ORS). However, since submitting the initial Transition Plan on October 13, 2014, Oregon has determined that changes are needed to OARs, not because of inherent areas of non-compliance, but to ensure clarity and facilitate initial and ongoing provider compliance. Specific changes in OARs, policies, practices and contracts and changes found necessary to 1915(c) waivers, and 1915(i) and 1915(k) State Plan Amendments will occur after the provider self-assessment and individual's experience assessment phase. The scorecard was shared with the Stakeholders at a meeting on August 5, 2014, updated, and posted on Oregon's HCBS website (HCBS website) on March 9, 2015. Oregon's HCBS website address is http://www.oregon.gov/dhs/seniors-disabilities/HCBS/pages/index.aspx As updates to the transition plan and scorecard occur, the HCBS website will be updated with current materials. This allows Stakeholders and the broader public the chance to provide feedback on the scorecard as well as the transition plan. Their insight and input, based on their individual

experience, into the actual level of compliance is vital as DHS and OHA move towards full compliance. Based on the initial regulatory assessments, DHS and OHA have determined that Oregon's regulations meet the following requirements: • The setting is selected by the individual, or their representative, from among all available options, including services and supports in the individual's home, unless there are legal impediments that prohibit the individual from being served in a particular setting. • The setting choice is identified and documented in the person-centered service plan and are based on the individual's needs, and preferences. • The delivery system facilitates individual choice regarding services and supports, and who provides them. Based on the assessment of statutes, rules, policies and contracts, DHS and OHA have determined that regulations for most residential setting types meet the following 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 personal protective interventions. This is limited to individuals who are a danger to themselves or others and need emergency interventions to be protected. • 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. During Phase II and III, DHS and OHA will work to assure that each residential site meets the following 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. Also, some non-residential sites may need to adapt and change to comply with the HCBS setting requirements. Facility-based non-residential services, including employment and other day services, must be provided in settings that are integrated in and support full access to the greater community. This includes opportunities to seek employment and work in competitive and integrated settings. As part of Oregon's efforts to address non-residential settings, DHS is actively pursuing its Employment First policy. Former Governor Kitzhaber issued an initial Executive Order in April 2013 which directs state agencies to take numerous steps that will advance the Employment First policy. In 2014, the Oregon Legislature provided significant additional funding to carry out the measures required by the Order. The Executive Order was revised in January 2015. Oregon Administrative Rules (407-025) have been adopted to carry out the Executive Order, a wide array of stakeholders and advocacy groups are engaged in this initiative, and efforts to fully implement the Order are well under way. Throughout the transition process, providers are being given concrete instructions and technical assistance regarding areas they must address before CMS's final compliance deadline. Providers will have until September 30, 2018 to make all necessary changes. This allows sufficient time for DHS and OHA to assist individuals in transitioning to other facilities that meet the HCBS requirements, if necessary.

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

Provider, Individual and Delivery System Education DHS and OHA will develop a variety of ways to educate Stakeholders and the broader public. These methods include the use of electronic media and community meetings. DHS and OHA have developed a website designed to provide information and provider training materials in order to keep the broader community informed about the transition progress. The HCBS website will also allow the broader community to have continuous input into the transition process.

Individual and Family Education (July 2014 – March 2019) In collaboration with Stakeholders, and based upon the results of compliance activities conducted by the agencies and their service delivery systems, DHS and OHA will develop educational materials for consumers/individuals, guardian, representatives and families. These materials will be posted on the HCBS website and provided in regional information meetings. The initial information will explain the new requirements and how they will be included in the assessment and transition process. The educational information will also explain the impact of the new CFRs 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 will be routinely updated and posted on the HCBS website. DHS and OHA will recommend that providers hold resident and family meetings.

Provider 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 will continue to meet with providers and their associations throughout the transition time period. DHS and OHA are developing strategic technical assistance by drafting and issuing fact sheets, frequently asked questions (FAQs), and responding to questions from providers. DHS and OHA will post materials on the HCBS website and provide it in regional trainings. DHS and OHA will host regional trainings throughout the state. At the advice of the Stakeholders, DHS and OHA will invite providers,

consumers, family members and delivery system staff members to the same training to ensure that the information is shared consistently to everyone. Trainings will be held during the day and in evenings to facilitate attendance. DHS and OHA will make recordings of the training content available on-line so that interested parties may watch it at their convenience. Initial training activities will focus on the new requirements and how to complete the provider self-assessment. The training materials will be presented to Stakeholders for review by May 1, 2015. DHS and OHA will post the training materials on the HCBS website. Additional training will be developed and disseminated regarding individual's rights, protections, person-centered planning, community inclusion and how individual "Modifications to the Conditions" during the person-centered planning process will be implemented. DHS and OHA will continue to engage Stakeholders to develop educational materials on how to work with high risk and vulnerable individuals within the new requirements. Additionally, as these are the homes of the individuals we serve, DHS and OHA will provide clarity on the requirement that all provider-owned, operated, or controlled residential settings maintain a "home-like" quality. The information will be routinely updated and posted on the HCBS website.

Delivery System Education (November 2014 – March 2019) DHS and OHA will ensure that service delivery system staff members (case managers, personal agents, service coordinators, licensing staff and protective service staff) receive 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 training will 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 will include curricula on supporting informed choice, identify areas that providers must address and support implementation of the transition plan. It will also include individuals' rights, protections, person-centered thinking, and community inclusion.

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

Provider Self-Assessment Tool (August 2015 – September 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 providerowned, 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, nonresidential, etc.) In consultation with Stakeholders, DHS and OHA have developed a Provider SelfAssessment Tool (PSAT) for providers of provider-owned, controlled, or operated residential and non-residential settings. The provider of each site will receive the Provider PSAT with instructions and required timelines for completion. All HCBS providers of provider-owned, controlled, or operated settings will be required to complete the self-assessment for each of those HCBS sites they operate. Providers will be encouraged to include the individuals receiving services, their family members/representatives, advocates and others in their assessment process. Providers will be required to include in their self-assessment a description of their self-assessment process, including participation of any individuals listed previously. DHS and OHA will provide guidance to providers on how to accomplish this activity. Some of the guidance will be factsheets, instructions, and FAQs. Providers must complete and return the PSAT to DHS and OHA within 60 calendar days of receipt.

Individual Experience Assessment (August 2015 – September 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, DHS and OHA will actively engage with individuals receiving Medicaid-funded HCBS services as specified in this plan, their families and their advocacy organizations to gather their opinion and insight on how providers are meeting the HCBS requirements. In consultation with Stakeholders, DHS and OHA are developing an Individual Experience Assessment (IEA) for individuals receiving Medicaid-funded HCBS services in provider-owned, controlled, or operated residential settings and nonresidential settings. The IEA will focus primarily on whether the individual feels his or her service experiences align with what is required in the settings requirements. With advice and feedback from Stakeholders, DHS and OHA are determining the best way to maximize individual participation in the IEA process. All Medicaideligible individuals receiving HCBS as identified in this transition plan will receive the opportunity to participate in the IEA process. The results of the IEAs will allow DHS and OHA to gain critical insight about how the individuals receiving services perceive their experiences both with the service delivery system and their service provider. The IEA will indicate if it was completed by the individual, the family, the individual's guardian, or others. Additionally, the IEA will ask if the individual felt that they were able to select their services from all available service options and all available providers. DHS and OHA will provide feedback to the provider, based on their analysis and evaluation of the IEA and require them to address the findings in their final adaptation plan.

Validation of Providers' Self-Assessment (September 2015 – February 2016) The Individual Experience Assessment and Provider Self-Assessment will be conducted simultaneously. DHS and OHA will use a variety of ways to validate the

PSAT. The first step is the IEA. Ideally, at least one individual from each provider site will complete and return the IEA. As mentioned above, the IEA will validate or contradict the provider's self-assessment. DHS and OHA will also conduct site visits on a random sample of individual sites, separate from and an in addition to licensing/certification reviews, to determine the validity of the assessment responses. Through education and technical assistance efforts, DHS and OHA will be able to corroborate information provided by providers and service recipients. DHS and OHA will also provide and publicize the opportunity for the public to submit feedback on providers' compliance and/or progress. As a key component, DHS and OHA will ask 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 will leverage existing organizational partners such as the Governor's Advocacy Office, adult protective service staff, licensing staff and case managers 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 anticipate that it will have the completed PSATs and IEAs returned by 09/30/2015. DHS and OHA expect to analyze approximately 4000 completed PSATs. IEAs will be sent to approximately 30,000 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). Dependent upon the rate of return of IEAs, DHS and OHA anticipate that it will take 5 months to compile, analyze and compare the results of the PSATs and IEAs. After results are compiled, analyzed, and compared, as detailed in the attached timeline, DHS and OHA will amend the Global Transition Plan to include assessment results, analysis, and plan for remediation activities.

Oregon anticipates submitting its amended Global Transition Plan on July 1, 2016. The amended plan will also include the aggregated number of sites that fully align with federal requirements, the aggregated number of sites that do not currently comply and require modifications, and the aggregated number of sites that cannot meet the requirements and will require termination of the provider's Medicaid HCBS contract. Additionally, DHS and OHA will identify and provide justification/evidence of any sites not identified in Phase IV below, that are presumptively non-HCBS but for which DHS and OHA will request heightened scrutiny. Prior to submission to CMS of the amended Global Transition Plan, DHS and OHA will commence a 30 calendar day public notice and comment period with at least one public forum. The public notice will include information about how individuals can request a printed copy of the amended Transition Plan.

Phase IV. Heightened Scrutiny Process (October 2014 – June 2016)

Facilities and Programs Oregon has Initially Identified to Require Heightened Scrutiny Based on an initial offsite review of provider-owned, controlled, or operated residential HCBS settings, Oregon is pro-actively asking CMS to approve the following facility or program types through the heightened scrutiny process. DHS and OHA do not believe that these types of facility or programs in Oregon have the effect of isolating individuals receiving HCBS from the broader community and they serve a critical function in meeting the needs of individuals receiving HCBS. • Facilities in the same building, on the grounds of, or immediately adjacent to, inpatient treatment facilities or public institutions o These facilities or programs will meet the HCBS requirements regardless of the location and will not isolate individuals from the broader community. In some cases, the facilities are co-located with institutions to provide individuals the ability to gain additional skills that allow them to transition to other settings in the community. In other cases, the HCBS setting was not intentionally located adjacent to an inpatient treatment facility or public institution. As an example, an adult foster home, a traditional family home, may be adjacent to the Oregon State Hospital but is operated by an independent provider. These settings are often located where a residential neighborhood begins and individuals have full access to the community. In the few instances where the location of the setting creates concerns of potential isolation from the broader community, DHS and OHA will work with providers to identify additional resources that facilitate increased access to the broader community.

Review for Heightened Scrutiny (October 2014 – June 2016)

Throughout Phase III of the Global Transition Plan, DHS and OHA will assess each site to determine if it does not appear to meet the HCBS settings requirements and requires Heightened Scrutiny. This will 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 criteria for determining which sites will require Heightened Scrutiny (June 2015).
• Using the provider assessment, IEA responses, and additional criteria to determine and propose if a site meets the definition of an HCBS site. (September 2015 - February 2016)
• Conduct on-site review of sites determined to require heightened scrutiny. (February 2016 – June 2016)
• Posting information on each site that requires Heightened Scrutiny on the HCBS website and asking for public comment. (July 2016)
• Providing opportunity for sites to request an Administrative Review of DHS's and OHA's determination. (August 2016 - September 2016)

• Compiling a report of the settings presumed to require heightened scrutiny and submit evidence and justification to CMS to apply review process (described in Phase III). (September 2016)
• Expected receipt of CMS response. (December 2016)
• Determining remediation strategies and next steps (September 2016 –September 2018)

Phase V. Remediation Activities (May 2015 – September 2018)

After the PSAT and IEA results for all providers are analyzed, DHS and OHA shall supply each provider an initial response detailing findings and the areas that they must change to come into compliance with the HCBS regulations. The initial response will be sent no later than February 2016. The initial response will include a template, developed with Stakeholders, for providers to use to develop a 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. This submission will trigger a review process through which an administrative review committee (ARC) will make a final determination on the areas that must be remediated. The ARC will make a final determination within 30 calendar days. DHS and OHA will then send the provider a final response detailing the ARC's determination and identify changes that must be addressed in the provider's Adaptation Plan.
Prior to December 2015, DHS and OHA will create an advisory panel, comprised of Stakeholders, to develop evaluation criteria for the Adaptation Plans. The advisory panel will also evaluate the Provider Adaptation Plans, using the developed criteria, and provide recommendations to DHS and OHA to ensure the plans meet HCBS regulations. This advisory panel will provide critical insight as DHS and OHA determine if providers have submitted satisfactory Adaptation Plans. Plans that do not meet the 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. 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.

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

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 compliance and assuring providers' progress on their adaptation plans. DHS and OHA will 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 quality management 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 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. Providers must be in full compliance with the regulations by September 30, 2018. This timeline assures that DHS and OHA have adequate time to assist individuals, using a person-centered planning process, to choose alternative services and settings options if their individual provider is unable to meet full compliance, If, by September 30, 2018, the provider is not in full compliance, DHS and OHA will begin working with individuals and their family members or representatives to transition to a site that is in compliance. This will allow more than 5 full months to transition individuals by CMS's final compliance deadline. Individuals must be moved to

compliant sites 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. DHS and OHA will notify service recipients in writing by 09/30/2018 if their current provider is not in compliance with the HCBS regulations. The notification will explain the individual's rights and options available to them. It will also define the process and timeline to help the individual make an informed choice of another site that is in compliance. Individuals will be able to select from all available settings. Service delivery system staff will assist individuals and their representatives in the person-centered service planning process and will ensure that all critical services and supports are in place prior to the individual transitioning to another site. Providers who are unable to come into compliance will no longer be able to contract with DHS and OHA effective March 1, 2019. Providers who are not able to achieve full compliance by September 30, 2018 will be required to assist the DHS and OHA in transitioning individuals by February 28, 2019 to other sites that are in compliance.

Key Action Items	Approx. Start Date (first day of month)	Approx. End Date (last day of month)
Pre Plan Activities		
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
Phase I- Initial Regulatory Assessment		
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
Oregon Transition Plan Development and Submission		
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
Phase II- Statewide Training and Education Efforts		
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
Share materials with stakeholders	Apr- 15	Ongoing
Post materials on website	May- 15	Ongoing
Host regional training and information meetings for individuals, providers, and case managers	Jun- 15	Jul- 15
Phase III- Provider Self-Assessment and Individual Experience Assessment		
Provider Self-Assessment		
Develop Provider Self-Assessment Tool (residential and nonresidential providers)	Oct- 14	Apr- 15
Share with Transition Stakeholder Group	May- 15	May- 15
Develop online survey tool	Jun- 15	Jul- 15
Send provider self-assessment to residential and non-residential providers	Aug- 15	Aug- 15
Provider Self-Assessments completed and returned to State	Aug- 15	Sep- 15
Individual Experience Assessment		
Develop a survey for individuals receiving services	Oct- 14	Apr- 15
Share survey with Transition Stakeholder Group	May- 15	May- 15

Develop online survey tool	Jun- 15	Jul- 15
Send Individual Experience Assessments to individuals receiving HCBS	Aug- 15	Aug- 15
State and partners to conduct individual assessments, as necessary (in-person, phone)	Aug- 15	Sep- 15
Individual Experience Assessments completed and returned to State	Aug- 15	Sep- 15
Provide technical assistance to individuals	Aug- 15	Sep- 15

Provider Self-Assessment and Individual Experience Assessment Results and Responses

Develop and disseminate Adaptation Plan template for providers to develop their individual Adaptation Plan	Jun- 15	Jul- 15
State evaluates Individual Experience Assessments and Provider Self-Assessments (comparison of results from both)	Sep- 15	Feb- 16
State to provide initial notice of findings, including Adaptation Plan template, to residential and non-residential providers and recommendations for Adaptation plans	Sep- 15	Feb- 16
Providers may request a review of State's initial findings	Mar- 16	Mar- 16
State responds to provider's request for review of initial findings	Apr- 16	Apr- 16

Submission of Amended Global Transition Plan

State evaluates Individual Experience Assessments and Provider Self-Assessments (comparison of results from both)	Sep- 15	Feb- 16
State identifies necessary Transition Plan changes	Sep- 15	Feb- 16
State identifies settings that require heightened scrutiny	Feb- 16	Jun- 16
State amends Global Transition Plan	Mar- 16	Mar- 16
Stakeholder review of draft transition plan	Apr- 16	Apr- 16
30- day Public Comment Period	May- 16	Jun- 16
Amended Global Transition Plan Submitted to CMS	Jul- 16	Jul- 16
Expected response from CMS	Oct- 16	Oct- 16

Phase IV. Heightened Scrutiny Process

State evaluates Individual Experience Assessments and Provider Self-Assessments (comparison of results from both) and identifies settings that require heightened scrutiny	Sep- 15	Feb- 16
State conducts on-site reviews of settings identified to require heightened scrutiny per CMS's regulations	Feb- 16	Jun- 16
State submits evidence and justification to CMS for each setting that is presumed to be non-HCB but the State has determined to meet HCB requirements to apply heightened scrutiny review process	Sep- 16	Sep- 16

Phase V- Remediation Activities

Adaptation Plans

Update website to guide providers in making the necessary changes.	May- 15	Ongoing
Develop with Stakeholders an advisory panel and Adaptation Plan review criteria	May- 15	Dec- 15
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
State's will review appeal evidence and issue a final decision	Oct- 16	Oct- 16
Providers submit FINAL Adaptation Plan addressing State's findings	Nov- 16	Dec- 16
Develop a scorecard of provider's compliance	Jan- 17	Feb- 17
Post scorecard on website	Mar- 17	Mar- 17
Gather public input on provider's assessment	Apr- 17	Sep- 18

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	May- 15

Conduct formal rule making process	Jun- 15	Jan- 16
Public Notice and Submission of any necessary waiver amendments and SPAs.	Mar- 16	Dec- 16

Modifications to Conditions (Service Plans)

Develop policies and procedures on individual service plan modifications	Jan-15	Dec-15
Create expectations and a method for collecting data on an ongoing basis to measure the effectiveness of the modification	Jan- 15	Jul- 15
Develop timeframes for review of the data and effectiveness of the modification to ensure it continues to be appropriate.	Jan- 15	Dec- 15

Achieving Initial Compliance

Develop procedures for interviewing providers, individuals, family members and program inspections.	Jan- 15	Jul- 15 Develop policies and
procedures for Quality Assurance and Licensing staff to check progress on their adaptation plans.	May- 15	Jan- 16

Phase VI- Ongoing Compliance and Oversight

Develop ongoing monitoring and quality assurance processes	May- 15	May- 18
Assist individuals in finding and transitioning to alternative settings	Sep- 18	Feb- 19
Terminate Medicaid contracts with non-compliant providers	Mar- 19	Mar- 19
2 nd Individual Experience Assessment	Jul- 17	Dec- 17
3 rd Individual Experience Assessment	Jul- 19	Dec- 19

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:
Oregon Department of Human Services

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   Oregon Health Authority (OHA), the single state Medicaid Agency, and the Department of Human Services (DHS), the Operating Agency, have an Interagency Agreement (IAA) 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 and DHS will work in collaboration 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 and collaborate 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 the OHA Director for final approval.
- Waiver renewals, requests for amendments and 372 reports will be approved by OHA prior to submission to CMS.
- Correspondence with CMS is copied to OHA.

The Oregon Health Authority has oversight responsibility for all Medicaid programs, including the following functions related to HCBS waivers:
- Annual review of waiver enrollment measured against enrollment projections.
- Annual review of waiver expenditures measured against expenditure projections.
- Utilization management- OHA will review expenditures to ensure compliance with relevant statutory and regulatory authority and administrative rules and policies.
- Qualified Provider Enrollment and Termination - OHA will review provider enrollment and termination procedures and policies to ensure that Medicaid providers meet documented provider qualifications.
- Execution of Medicaid Provider Agreements - OHA will provide oversight to assure that Medicaid agreements are executed appropriately.
- 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 review waiver assurances and standards of quality and remediation activities.

The following language is excerpted from the current Article III of the Interagency Agreement between the Oregon Health Authority and the Oregon Department of Human Services titled “Roles and Responsibilities”. The agencies renew this agreement every two years:

3.0.1 A Medicaid/CHIP Policy Steering Committee (Steering Committee) for OHA and DHS will meet at least twice per year to review Medicaid/CHIP-related policy. The Steering Committee will be comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of responsibilities, including establishment of a strategic plan for the two agencies.

3.0.2 A Medicaid/CHIP Operations Coordination Steering Committee (MOCSC)for OHA and DHS will meet at least quarterly to coordinate all mutual policy issues related to the operation and administration of the Medicaid/CHIP program including state plan amendments, waiver requests, rules, procedures, and interpretive guidance. The MOCSC will be comprised of executive level staff and subject matter experts.

3.1.1 OHA, as the single state Medicaid/CHIP agency, has an administrative oversight function to ensure that all funds expended under such authority are spent in accordance with federal and state law, federal and state regulations, the State Plan, State Plan Amendments, and Waivers. In accordance with those functions:

A. Any Medicaid/CHIP program, project or expenditure which in whole or in part utilizes financial resources that are within OHA’s legislative functions and duties, must have approval from OHA.

B. No DHS Medicaid/CHIP project within OHA’s functions and oversight responsibilities will be submitted to CMS for approval without prior approval by OHA. Projects will be developed according to the process description in Paragraph 3.0 of this Article.

3.1.2 OHA will exercise oversight of Medicaid/CHIP programs by participating in related committees and approving DHS reports and documents as necessary. OHA will review DHS quality control processes for Medicaid/CHIP programs managed by the 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.

3.2 RULE DEVELOPMENT AND IMPLEMENTATION

OHA as the single state Medicaid/CHIP agency is responsible for approving rules, regulations and policies that govern how the state plan and waivers are operated. Both agencies will work collaboratively in accordance with this Agreement, ensuring that OHA retains the authority to discharge its responsibilities for the administration of the Medicaid/CHIP program pursuant to 42 C.F.R. Sec. 431.10 (e).

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

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
DHS is a contracted entity, per the OHA/DHS Interagency Agreement, that performs operational and administrative functions on behalf of the Medicaid Agency.
Within the OHA/DHS Interagency 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, 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.
The agencies renew this agreement every two years.

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

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

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

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

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

A Community Developmental Disabilities Program (CDDP) is an entity that is responsible for determining eligibility, conducting abuse investigations, planning for delivery of services and providing case management services as authorized under a 1915(b)(4) waiver for persons with intellectual disabilities or other developmental disabilities. CDDPs operate in all areas of the state under an Intergovernmental Agreement (IGA) with DHS or a local mental health authority. DHS retains the authority to operate as a CDDP in any county of the state as needed.

☑ **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:

Local agencies, under contract with DHS or a local mental health authority, may operate as CDDPs. Operating as a CDDP, local contracted agencies are responsible for determining eligibility, conducting abuse investigations, planning for delivery of services and providing case management services as authorized under a 1915(b)(4) waiver for persons with intellectual disabilities or other developmental disabilities. DHS retains the authority to operate as a CDDP in any county of the state as needed.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
Oregon Health Authority as Medicaid Agency and Department of Human Services as the OHCDS.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
OHA will exercise oversight of Medicaid/CHIP programs by participating in related committees and approving 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 term 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. OHA reviews program oversight on a continual basis and as described in the performance measures in the QIS. OHA will designate internal staff to review the processes employed, and outcomes reported, by 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 interagency agreements between DHS and OHA about Medicaid/CHIP program operations and their administrative issues.
Roles of the MOCSC include, but are not limited to:
- Providing high level oversight and decision-making on the operations of the Medicaid/CHIP programs;
- Ensuring the objectives of the interagency agreements between DHS and OHA about Medicaid/CHIP program operations and their administrative issues are being met;
- Ensuring that members fully discuss Medicaid/CHIP business and fiscal and operations issues that require decisions and resolution;
- Providing a high-level forum for the regular exchange of information on Medicaid/CHIP operations.
- Providing recommendations to the JOSC or the Medicaid/CHIP Policy Steering Committee/Joint Policy Steering Committee (JPSC) that link the business objectives of OHA and DHS (and the joint administrative processes applicable to Medicaid/CHIP programs operational and business processes) and may significantly affect both agencies; and
- Providing timely access, as needed by committees or workgroups, to review and recommend necessary actions, including an expedited review and decision-making process to accommodate time lines.
- Referring concerns or disagreements related to decisions by the MOCSC to JOSC or JPSC as appropriate.
DHS Annual Support Services Field Review - Statistically valid random sample of DDS waiver service recipients. Review conducted on-site. Review includes a review of: Individual Support Plans (ISP), Level of Care, incident reporting, provider qualifications, and case documentation.
Annual HCBS Waiver Review- of services for a statistically valid number of individuals in waiver services conducted
by DHS and CDDP staff. Data is submitted to DHS for entry into a central database and reporting. OHA will review a random sample of files already reviewed by DHS to assure oversight and quality.
Licensing or Certification Reviews- Every five years. The Department will conduct a certification review of the brokerage services prior to the renewal of the certificate. The review will be conducted 30 to 120 days prior to the expiration of the certificate.
Office of Adult Abuse Prevention and Investigation (OAAPI) annual reports- statewide data by county, type, outcome, victim, perpetrator, provider, etc.;
OAAPI review of abuse investigations;
Serious Event Review Team (SERT) review of provider sanctions- during regularly scheduled meetings.
Contested Case Review- As requested.
DD Complaints and Grievances Database- As requested.
DHS Audit Unit, Secretary of State- other internal or external periodic audit activities.
Improvement Projects- Consumer satisfaction survey of in-home service recipients conducted approximately every 2 years.
The above-referenced Office of Adult Abuse Prevention and Investigation, DD Licensing Unit, and SERT are all part of Department of Human Services, Oregon's operating agency.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the 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:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☐ **Annually**

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM3:The number and percent of waiver amendments reviewed with Oregon's Tribal partners prior to submission to CMS N = Number of waiver amendments reviewed with Oregon's Tribal partners prior to submission to CMS D = Number of waiver amendments submitted to CMS.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM4:The number and percent of Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) meetings held between the operating agency (OA) and the SMA per year (MOCSC meeting agendas cover 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM5:Waiver expenditures managed against approved levels PERFORMANCE MEASURE: 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):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
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):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
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):
Provider performance monitoring
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
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:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: biannually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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 is reviewed and analyzed on a continuous and ongoing basis by the OHA liaison to DHS to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Upon completion of OHA' analysis and review of DHS' quality assurance data and reports, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the MOCSC.
The Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) annually reviews the reports and document DHS and OHA remediation efforts.
A Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) for OHA and DHS meet at least twice per year to review Medicaid/CHIP-related policy. The Steering Committee will be comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of policy-related issues and delineation of responsibilities, including establishment of a strategic plan for the two agencies.
A Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) for OHA and DHS meet 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 MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and DHS.
DHS staff address individual problems with 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 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. Non-compliance will be determined by any performance measure that falls below 86% accuracy.
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)
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*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☑	Developmental Disability	0		☑
	☑	Intellectual Disability	0		☑
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

This waiver serves individuals of any age who reside in their own or family home or in licensed/certified residential settings.

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:

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	14640
Year 2	14750
Year 3	14900
Year 4	15120

Waiver Year	Unduplicated Number of Participants
Year 5	15320

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:

The waiver provides for entrance of all eligible individuals.

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

Specify:

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

1902(a)(10)(A)(i)(VIII)and

1902(a)(10)(A)(i)(III), (IV), (VI), and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); and 1931(b) and (d) of the Act.

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- [ ] **A special income level equal to:**

Select one:

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

Specify percentage: [ ]

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

Specify dollar amount: [ ]

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

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 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:

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.

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

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

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

Specify the entity:

- (●) **Other**

Specify:

CDDP, Services Coordinators are responsible for completing initial level of care evaluations and annual level of care reevaluations.

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:

Local CDDP Services Coordinators performing the initial level of care evaluation, as well as the DHS Diagnosis and Evaluation Coordinator who confirms the LOC, must be a Qualified Mental Retardation Professional, as defined in 42CFR 483.430(a); OR meet the qualifications set forth in Oregon Administrative Rule:
A person employed as a CDDP Services Coordinator must have knowledge of the public service system for developmental disability services in Oregon and at least:
~ A bachelor's degree in behavioral science, social science, or a closely related field; or
~ A bachelor's degree in any field AND one year of human services related experience; or
~ An associate's degree in a behavioral science, social science, or a closely related field AND two years human services related experience; or
~ Three years of human services related experience.
Persons who do not meet the minimum qualifications set forth in rule may perform those functions only with prior approval of a variance by the Department. Prior to employment of an individual not meeting minimum qualifications of a Services Coordinator, the CDDP must submit a written variance request to the Department. The request will include:
~ An acceptable rationale for the need to employ an individual who does not meet the qualifications; and
~ A proposed alternative plan for education and training to correct the deficiencies. The proposal must specify activities, timelines and responsibility for costs incurred in completing the plan.
~ A person who fails to complete a plan for education and training to correct deficiencies may not fulfill the requirements for the qualifications.

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.

DHS, with the assistance of CDDPs, uses the Level of Care Assessment form to determine an individual's ICF/IDD level of care eligibility for waivered services.
Services Coordinators (SC) at local CDDPs complete the initial Level of Care Assessment form when an individual is requesting to enter a waivered service for the first time. CDDP Service Coordinator's review the form and reevaluate level of care annually thereafter.
The SC completes the initial Level of Care Assessment form using face to face, personal observations of the individual, interviews with the individual and others with personal knowledge of the individual, and documentation of the individual's functioning, such as standardized tests administered by qualified professionals as described in OAR.
Examples include:
~ Vineland;
~ Scales of Independent Behavior - Revised (SIB-R);
~ Adaptive Behavior Assessment Scale (ABAS); and
~ Adaptive Behavior Scale (ABS);
~ The Service Coordinator's (SC) personal observations of the individual; and
~ Information from the individual's primary caregiver
DHS employs Diagnosis and Evaluation Coordinators (D & E Coordinator), to whom the SC sends the initial Level of Care Assessment form for review and LOC eligibility determination. The D & E Coordinator determines from the information provided on the Level of Care Assessment form whether the individual meets the ICF/IDD level of care eligibility.
The D & E Coordinator reviews the Level of Care Assessment form to ensure:
~ That the individual has a qualifying diagnosis of a Developmental/Intellectual Disability; and
~ A need for supports in *one* or more of the following areas:
(i) Communication;
(ii) Functional academics;
(iii) Self-direction;
(iv) Leisure;
(v) Social;
(vi) Community use;

(vii) Home or school living;
(viii) Self-care;
(ix) Health and safety; or
(x) Work .
A need for supports may include cueing, reminders, redirection, reassurance, set-up, stand-by or hands-on. In the event the completed Level of Care Assessment form does not reflect that an individual has a need for supports in any of the areas listed above, the D & E Coordinator will contact the CDDP SC who completed the Level of Care Assessment form for more detailed information regarding the individual's functioning and need for supports. If the individual has support needs that should be reflected on the Level of Care Assessment form, the D & E Coordinator will document this information and make a determination of ICF/IDD level of care eligibility.
OAR 411-320-0080 governs the criteria used to determine DD eligibility.

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:

Evaluations to establish the presence of a developmental disability, including an intellectual disability may be conducted by physicians or psychologists.
After the developmental disability has been established, the initial Level of Care Assessment form is completed by the SC, during a face to face meeting with the individual, in order to establish ICF/IDD level of care. DHS' Diagnosis & Evaluation (D&E) Coordinator designates approval or disapproval and signs all initial Level of Care Assessment forms. Once Level of Care determination has been made by the D&E Coordinator, the effective start date for waiver eligibility will be the latter of the following:
~ The date of the individual's signature on the Level of Care Assessment form, or
~ The date of enrollment in a DD Home and Community-Based Waiver service.
After the initial LOC evaluation, reevaluation occurs annually, prior to the renewal of the service plan, or as needed if the individual's care needs substantially change. The reevaluation is conducted by a qualified service coordinator during a face to face meeting with the individual and the Level of Care Assessment form is updated as needed and the renewal is confirmed by the SC's signature. Reevaluations are not reviewed by a DHS D&E coordinator.

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):*

CDDP Service Coordinators can conduct the annual face-to-face Level of Care reevaluation at the same time as the annual ISP meeting or at a regularly scheduled face-to-face visit, such as monitoring visits, no more than 60 days prior to the ISP implementation date. The meeting must be conducted within the mandated 12-month time frame from previous re-evaluation.

Community Developmental Disabilities Programs (CDDP) are given the latitude to use either a tickler file system or a computer tickler system to ensure timely reevaluations of level of care (LOC). This is determined by technology available in each CDDP or the process that works best for them on an individual basis.
Service Coordinators are required to conduct an individual's annual level of care reevaluation face-to-face to ensure the health and welfare of the recipient. Completion of the annual level of care (LOC) reevaluation cannot exceed 12-months from the date of the last reevaluation.
DHS Central Office staff and CDDP staff conduct an annual HCBS Waiver Review of services for a statistically valid number of individuals in waiver services. The annual HCBS Waiver Review report details aggregate data statewide, by CDDP and brokerage. By conducting the annual HCBS Waiver Review, the state is ensuring that:
~ The LOC Form is in place;
~ The annual LOC Form is timely and current;
~ The LOC Form is reviewed at least annually; and
~ There is documentation present supporting eligibility and need for ICF/IID LOC
The review crosses all waivers and CDDPs. Data is submitted to DHS by CDDPs for entry into a central database, analysis, and reporting to utilize for prospective quality improvement activities.

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:

Copies of initial Level of Care Assessment forms will be kept at DHS, Central Office. Original copies of the initial level of care evaluation and annual reevaluation form are kept by the services coordinators, in the consumer's file, at the CDDPs for a minimum period of three years.

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: biennially	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
	☐ **Weekly**	☐ **100% Review**

☐ **State Medicaid Agency**		
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10%

		sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☑ **Annually**

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

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:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

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

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Biannually

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 is reviewed and analyzed on a continuous and ongoing basis by the OHA liaison to DHS to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Upon completion of OHA' analysis and

review of DHS' quality assurance data and reports, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the MOCSC. The Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) annually reviews the reports and document DHS and OHA remediation efforts. A Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) for OHA and DHS meet at least twice per year to review Medicaid/CHIP-related policy. The Steering Committee will be comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of policy-related issues and delineation of responsibilities, including establishment of a strategic plan for the two agencies. A Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) for OHA and DHS meet 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 MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and DHS. DHS staff address individual problems with 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 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. Non-compliance will be determined by any performance measure that falls below 86% accuracy.
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)
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*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Oregon assures that individuals who are eligible for services under the waiver will be informed, during initial completion of the Level of Care (LOC) form evaluation and eligibility process, of feasible alternatives for long-term care and given a choice as to which type of services they are eligible to receive. When an individual is determined to require the level of care provided in an ICF/IID, the individual or his or her legal representative will be:

1) Informed of any feasible alternatives available under the waiver and Medicaid State Plan: and
2) Given the choice of either institutional or home and community-based services.

Service Coordinators document the offer of choice on the initial LOC form. The offer of choice is given before an individual enters a waiver service. The LOC form is used to document that the offer of choice was presented to the individual or his/her legal representative, and how the individual or his/her legal representative indicated their choice of service. The individual's or his/her legal representative's signature is obtained when possible. If it is not possible to obtain the individual's or legal representative's signature on the form, confirmation of the choice can be documented in the following manner: witnessed mark of the individual or legal representative, letter from the legal representative indicating choice, or witnessed and documented phone conversation with the individual or legal representative regarding choice.

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

Copies of initial level of care evaluation forms will be kept at DHS, Central Office. Original copies of the initial LOC evaluation and annual LOC reevaluation form are kept by the services coordinators, in the consumer's file, at the CDDPs for a minimum period of three years.

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):
Linguistic Competence & LEP Persons
CDDPs address the language needs of their geographical area through translated brochures, flyers and other relevant information regarding services. CDDPs, when possible, employ bi-lingual Services Coordinators that reflect the primary local languages of the individuals and families within the county. CDDPs collaborate with school districts and other local public entities to share interpretive services.

The Department of Human Services, Office of Multicultural Health provides guidance and technical assistance to DHS in fulfilling its responsibilities to provide meaningful access to limited English proficient persons (LEP). Language for LEP individuals can be a barrier to accessing important benefits or services, understanding and exercising important rights, complying with applicable responsibilities, or understanding other information provided by Federally funded programs and activities. In certain circumstances, failure to ensure that LEP persons can effectively participate in or benefit from Federally assisted programs, may violate Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d and Title VI regulations against national origin discrimination. DHS receives funds from several Federal Agencies for an array of public health programs and services that fall under these requirements.

DHS follows the Department of Administrative Services standards. DHS is committed to improving the accessibility of these programs, services and activities to eligible LEP persons. When a Limited English Proficient (LEP) person attempts to access waiver services, DHS notifies the person that language services are available. DHS staff inform the LEP person that he or she has the option of having an interpreter without charge, or of using his or her own interpreter. Considerations are given to the circumstances of the LEP and whether there may be concerns over competency, confidentiality, privacy, or conflict of interest. DHS staff do not require LEP persons to use family members or friends as interpreters.

Many vital forms and notices are available for applicants and recipients in languages that are used by a significant number of individuals in the state. Most frequently, documents are translated into Russian, Vietnamese, and Spanish and are available on the Department's website or in hard copy at the local office.

Language assistance is available for verbal communications through a contractor. Oregon DHS has also established the

following Web-based resources available through DHS's web site at: www.oregon.gov/DHS/ph/omh/lep/shtml.

Checklist to Facilitate the Development of Linguistic Competence within Primary Health Care Organizations (pdf): Designed to assist primary health care organizations in developing policies, structures, practices and procedures that support linguistic competence.

Executive Order 13166[www.usdoj.gov]:
Improving Access to Services for Persons with Limited English Proficiency

Commonly Asked Questions And Answers Regarding Executive Order 13166

Multi-language Translations of Forms:
The documents on this website are intended to assist agencies that receive federal financial assistance in their planning efforts to ensure that their program services address meaningful access for all of the people they serve, including those who are limited English proficient.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Employment Path Services		
Statutory Service	Supported Employment - Individual Employment Support		
Statutory Service	Waiver Case Management		
Other Service	Direct Nursing		
Other Service	Discovery/Career Exploration Services		
Other Service	Environmental Safety Modifications		
Other Service	Family Training - Conferences and Workshops		
Other Service	Financial Management Services		
Other Service	Specialized Medical Supplies		
Other Service	Supported Employment - Small Group Employment Support		
Other Service	Vehicle Modifications		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Prevocational Services

Alternate Service Title (if any):
Employment Path Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Employment Path Services provide learning and work experiences, including volunteer opportunities, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings.
Services are expected to occur over a defined period of time, as outlined in each individual's ISP, and services and supports should be designed to support successful employment outcomes consistent with the individual's personal and career goals as identified in his or her ISP.

The optimal and expected outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated employment for which an individual is compensated at or above the state's minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Services are intended to develop and teach general skills to improve an individual's ability to communicate effectively with supervisors, co-workers and customers; understanding of generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; understanding of general workplace safety.

Employment Path Services may be provided in integrated community settings and fixed-site facilities and are distinguishable from non-covered vocational services by the following criteria:
• The services are provided to individuals who are expected to be able to join the general work force with the assistance of supported employment services;
• The service is primarily directed at teaching non-job task specific skills that will lead to greater opportunities for competitive and integrated employment and career advancement at or above the state's minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities;
• The ISP does not define the goal or purpose of the service as maintaining the individual in Employment Path Services or sheltered work.

Employment Path Services should be reviewed and considered as a component of an individual's ISP no less than annually and more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's personal and career goals. The presumption in considering these services is that all individuals eligible for services under this waiver are capable of working in an integrated employment setting and earning at least minimum wage. Consistent with the person-centered approach to these services, individuals should be encouraged, on an ongoing basis, to explore their interests, strengths, and abilities relating to integrated employment. As a component part of this service, employment service providers should be helping individuals identify and pursue career advancement opportunities that will move them toward individual integrated employment at competitive wage (with individual supported employment services as necessary Discovery/Career Exploration services are detailed more fully and are billed separately under the Service Title: Discovery/Career Exploration Services contained in this waiver.

An individual's ISP may include more than one non-residential habilitation service; however, they may not be billed for during the same period of time (e.g., the same hour).

Participation in Employment Path Services is not a required pre-requisite for individual or small group supported employment services provided under the waiver.

Transportation provided during the course of this service is included as a component part of Employment Path Services and is included in the rate paid to providers for these services. Transportation between the individual's place of residence and an Employment Path service site is not a component part of the service and is not included in the rate paid to providers of these services.

*Personal care/assistance may be a component of Employment Path services, but may not comprise the entirety of the service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
An individual may receive any combination of Small Group Employment Services, and Employment Path Services, the total of which (including any Supported Employment - Individual Employment services received) shall not exceed an annual average of 108.5 hours per month.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Employment Path Services Provider
Agency	Employment Path Services Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Path Services

Provider Category:
Individual

Provider Type:
Employment Path Services Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

(a) Maintain a drug-free work place;

(b) Be at least 18 years of age;

(c) Have approval to work based on a background check completed by the Department as described in OAR 407-007-0200 to 407-007-0370 and section (7) of this rule, and be free of convictions or founded allegations of abuse by the appropriate agency including, but not limited to, the Department, CDDP, CIIS, or Support Services Brokerage;

(d) Not have been convicted of any of the disqualifying crimes listed in OAR 407-007-0275, unless hired or contracted with prior to July 28, 2009 and remaining in the original position for which the independent worker was hired or contracted for;

(e) Be legally eligible to work in the United States;

(f) may not provide or deliver services to their spouse.

(g) Demonstrate by background, education, references, skills, and abilities that the personal support worker is capable of safely and adequately performing the tasks specified in an ISP, with such demonstration confirmed in writing by an individual or the representative of the individual, including:

(A) Ability and sufficient education to follow oral and written instructions and keep any required records;

(B) Responsibility, maturity, and reputable character exercising sound judgment;

(C) Ability to communicate with the individual; and

(D) Training of a nature and type sufficient to ensure that the independent worker has knowledge of emergency procedures specific to the individual;

(h) Maintain confidentiality and safeguard individual information. Unless given specific permission by an individual or the representative of an individual, the independent worker may not share any personal information about the individual, including medical, social service, financial, public assistance, legal, or interpersonal details;

(i) Not be on the list of excluded or debarred providers maintained by the Office of the Inspector General (http://exclusions.oig.hhs.gov/);

(j) Complete and submit a Provider Enrollment Agreement to the Department and possess a current provider number issued by the Department;

(k) Have a tax identification number or social security number that matches the legal name of the independent worker, as verified by the Internal Revenue Service or Social Security Administration; and

(l) If providing in-home services requiring professional licensure, possess a current and unencumbered license. The individual, representative of the individual, Department, CDDP, CIIS, or Support Service Brokerage must check the license status to verify the license is current and unencumbered.

(m) Any other competencies or training as required by the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS, Participant or designated representative.

Frequency of Verification:

Upon initial enrollment as a service provider and at request of participant or designated representative.

All employment service providers are subject to the same competency-based training, qualification, and credentialing requirements. This information is verified annually by the Service Coordinators and Personal Agents who authorize the Employment Service during the person centered planning process. It is also verified through both ODDS and Employment First Quality Assurance reviews.

Additionally, ODDS currently conducts criminal background checks and verifies other qualifications for independent providers every two years when provider enrollment agreements are completed.

*If an independent contractor or other Personal Support Worker (PSW), subject to the Collective Bargaining Agreement (CBA), is providing an employment service, the Oregon Home Care Commission (OHCC) will coordinate with ODDS to verify training requirements are met. This verification will occur no less than every two years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Path Services

Provider Category:
Agency
Provider Type:
Employment Path Services Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
OAR 411-340-0010 through 411-340-0180 or certificate issued by the Department to a service provider that certifies the service provider is eligible under the rules in OAR chapter 411, division 323.
Other Standard *(specify):*
Endorsement issued by the Department is also required for a certified service provider under OAR chapter 411, division 323 that has met the qualification criteria outlined in OAR 411-345-0010 - 411-345-0300.
Conditions that the Department may impose on an endorsement include but are not limited to: 1. Requiring additional staff or staff qualifications;
2. Requiring additional training;
For each specific geographic service area where services shall be delivered, a Medicaid Performing Provider Number assigned by the Department as described in OAR chapter 411, division 370.
Staff Qualifications:
1. Be at least 18 years of age;
2. Have approval to work based on current Department policy and procedures for background checks in OAR 407-007-0200 to 407-007-0370 and OAR 411-323-0050(6) of this rule;
3. Be literate and capable of understanding written and oral orders
4. Be able to communicate with individuals, physicians, services coordinators, and appropriate others;
5. Be able to respond to emergency situations at all times;
6. Be certified in CPR and First Aid by a recognized training agency within 90 days of employment;
7. Receive six hours of pre-service training prior to supervising individuals including:
A. mandatory abuse reporting training,

B. training to work with individuals with developmental disabilities, and
C. training on the support needs of the individual to whom they will provide support;
8. Receive 12 hours of job-related in-service training annually;
9. Have clear job responsibilities as described in a current signed and dated job description; and
10. If transporting individuals, must meet applicable Oregon Driver and Motor Vehicle Services Division requirements, have a valid Oregon driver's license and proof of insurance.
11. Staff supporting an individual with a history of behavior requiring protective physical intervention must be trained by an instructor certified in OIS curriculum
12. Any other specialized training as specified by contract requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHS

Frequency of Verification:
Initially and then every 5 years per OAR 411-323-0030.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):
Supported Employment - Individual Employment Support

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:
Supported Employment--Individual Employment Support services are for **individuals who, because of their disabilities, need on-going support to obtain and maintain a job in an integrated competitive, customized, or self-employment (including home-based) setting in the general workforce.

The optimal and expected outcome of this service is sustained paid employment in a competitive, customized, or self-employment setting, for which an individual is compensated at or above the state's minimum wage, with a goal of not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. This service should be designed to support successful employment outcomes consistent with the individual's personal and career goals.

Supported employment- Individual Employment Support services are individualized and may include:

• Job coaching - initial, and ongoing for:
o Individuals working in an individualized job in an integrated setting and earning at least minimum wage;
o Identification and delivery of services and supports that assist the individual in maintaining self-employment through the operation of a business. Medicaid funds may not be used to defray the expenses associated with operating a business.

• Job Development
o Support to obtain a job in an integrated employment setting in the general workforce for which an individual is compensated at or above the minimum wage, but ideally not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
o Support to the individual in an individualized job in an integrated setting who is not earning at least minimum wage and who needs a different job to earn at least minimum wage.
o Support to the individual in identifying potential self-employment business opportunities and assistance in the development of a self-employment business plan, including potential sources of business financing and other assistance in developing and launching a business. Medicaid funds may not be used to defray the expenses associated with starting up a business.

The rate methodology for job development is an outcome payment for job placement and outcome payment for 90 day retention so it's not considered a direct and/or non-direct billable unit of service.

**Leading up to job placement, the Job Developer's duties may include, but are not limited to, those outlined below in the "Between job placement and 90 day retention" section, as well as the following:

1. Supporting an individual to obtain an individual job in a competitive integrated employment setting in the general workforce, including customized employment or self-employment.
2. Working with the individual to develop a plan to obtain employment. Documenting or updating the individual's goals for employment, including the number of hours the individual wants to work, the wages and compensation the individual would like to receive in exchange for the work, as well as other career goals relating to the type of job the individual is interested in obtaining. The plan should also document the specific job development strategies to be used.
3. Meeting and networking with prospective businesses/employers to develop positive relationships and other staffing solutions. Support the individual in networking with businesses and prospective employers.
4. Meeting and partnering with Worksource Oregon, a statewide group of public and private partners dedicated to stimulating job growth by connecting businesses and workers with the resources they need to succeed. Worksource Oregon is one of many resources that a Job Developer can access in order to help link employers with employees. Meeting and partnering with Worksource could result in a possible job connection for the waiver participant and the individual may or may not go with the provider to meet/partner with Worksource.
5. Conducting labor market analyses to identify job opportunities that match an individual's career goals in terms of wages, hours, locating, interests and skills.
6. Supporting the individual and negotiate with prospective employers to carve or customize a job.
7. Evaluating potential employers, employer sites, and jobs, to identify potential obstacles, and negotiate for final job descriptions, including customized jobs, and, support the individual during the hiring and interview process.

Between job placement and 90 day retention, the Job Developer's duties may include, but are not limited to the following:

1. Establishing links with employers, in partnership with business services, to negotiate jobs with and for specific participants to obtain an individual job in a competitive integrated employment setting in the general

workforce, including customized employment or self-employment.
2. Acting as the employer's primary contact during the supported individual's first 90 days on the job.
3. Following up with the employer and providing support to the individual during the negotiation of any additional reasonable accommodations needed or identified after job placement.
4. Providing support for any additional job carving needed after job placement.
5. Finalizing job designs and job and task analyses, including special considerations for support. This includes the identification of core job functions and identification of the related and subtle skills necessary for a worker to be successful in the job.
6. Evaluating the type and amount of job-task and social-task supports necessary for employment success.
7. Facilitating relationships and natural supports with families, co-workers, supervisors, and other employer contacts.
8. Maintaining continued contact with the employer, supported individual, and job coach, until the job is stable and the individual has maintained employment for at least 90 days. The retention outcome payment helps ensure and set the expectation that the job developer continues to play a role during the supported individual's initial days on the job, and ensure a smooth transition to the job coach.

Between job placement and 90 day retention, the Job Coach focuses on the direct support needs of the individual and has duties that may include, but are not limited to the following:

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

All supported employment service options should be reviewed and considered as a component of an individual's ISP no less than annually and more frequently as necessary or as requested by the individual. The presumption in considering these services is that all individuals eligible for services under this waiver are capable of working in an integrated employment setting and earning at least minimum wage. Consistent with the person-centered approach to these services, individuals should be encouraged, on an ongoing basis, to explore their interests, strengths, and abilities relating to integrated employment. If an individual is employed and is already receiving supported employment services, Discovery/Career Exploration services may be used to find other competitive employment if the person wishes to seek additional hours of employment, to seek employment that is more consistent with the person's skills and interests or to explore advancement opportunities in his or her chosen career. Discovery/Career Exploration Services are detailed more fully and are billed separately under the Service Title: Discovery/Career Exploration Services contained in this waiver.

An individual's ISP may include more than one non-residential habilitation service; however, they may not be billed for during the same period of time (e.g., the same hour).

Ticket Outcome and Milestone payments do not conflict with CMS regulatory requirements and do not constitute an over payment of Federal dollars for services provided since payments are made for an outcome, rather than for a Medicaid service rendered.

*Personal care/assistance may be a component of Individual Employment Support services, but may not comprise the entirety of the service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service does not include support for volunteering.

This service does not include payment for the supervisory activities rendered as a normal part of the business setting.

Transportation between the individual's place of residence and the employment site is not a component part of supported employment individual employment support services, and the cost of this transportation is not

included in the rate paid to providers of these services. Transportation services may be available through another 1915 authority, such as the 1915 (k).

Supported Employment -Individual Employment (Job Development excluded) is limited to 40 hours per week. If an individual is receiving less than 25 hours per week of Supported Employment - Individual Employment services, they may also receive any combination of Small Group Employment Services, and Employment Path Services, the total of which (including the Supported Employment - Individual Employment services) shall not exceed an annual average of 108.5 hours per month.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Supported Employment - Individual Employment Support Provider
Agency	Individual Employment support Provider

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Supported Employment - Individual Employment Support Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
(a) Maintain a drug-free work place;

(b) Be at least 18 years of age;

(c) Have approval to work based on a background check completed by the Department as described in OAR 407-007-0200 to 407-007-0370 and section (7) of this rule, and be free of convictions or founded allegations of abuse by the appropriate agency including, but not limited to, the

Department, CDDP, CIIS, or Support Services Brokerage;

(d) Not have been convicted of any of the disqualifying crimes listed in OAR 407-007-0275, unless hired or contracted with prior to July 28, 2009 and remaining in the original position for which the independent worker was hired or contracted for;

(e) Be legally eligible to work in the United States;

(f) may not provide or deliver services to their spouse.

(g) Demonstrate by background, education, references, skills, and abilities that the personal support worker is capable of safely and adequately performing the tasks specified in an ISP, with such demonstration confirmed in writing by an individual or the representative of the individual, including:

(A) Ability and sufficient education to follow oral and written instructions and keep any required records;

(B) Responsibility, maturity, and reputable character exercising sound judgment;

(C) Ability to communicate with the individual; and

(D) Training of a nature and type sufficient to ensure that the independent worker has knowledge of emergency procedures specific to the individual;

(h) Maintain confidentiality and safeguard individual information. Unless given specific permission by an individual or the representative of an individual, the independent worker may not share any personal information about the individual, including medical, social service, financial, public assistance, legal, or interpersonal details;

(i) Not be on the list of excluded or debarred providers maintained by the Office of the Inspector General (http://exclusions.oig.hhs.gov/);

(j) Complete and submit a Provider Enrollment Agreement to the Department and possess a current provider number issued by the Department;

(k) Have a tax identification number or social security number that matches the legal name of the independent worker, as verified by the Internal Revenue Service or Social Security Administration; and

(l) If providing in-home services requiring professional licensure, possess a current and unencumbered license. The individual, representative of the individual, Department, CDDP, CIIS, or Support Service Brokerage must check the license status to verify the license is current and unencumbered.

(m) Any other competencies or training as required by the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS, Participant or designated representative.

Frequency of Verification:

Upon initial enrollment as a service provider and at request of participant or designated representative.

All employment service providers are subject to the same competency-based training, qualification, and credentialing requirements. This information is verified annually by the Service Coordinators and Personal Agents who authorize the Employment Service during the person centered planning process. It is also verified through both ODDS and Employment First Quality Assurance reviews.

Additionally, ODDS currently conducts criminal background checks and verifies other

qualifications for independent providers every two years when provider enrollment agreements are completed.

If an independent contractor or other Personal Support Worker (PSW), subject to the Collective Bargaining Agreement (CBA), is providing an employment service, the Oregon Home Care Commission (OHCC) will coordinate with ODDS to verify training requirements are met. This verification will occur no less than every two years. **

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Individual Employment support Provider
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
OAR 411-340-0010 through 411-340-0180 or certificate issued by the Department to a service provider that certifies the service provider is eligible under the rules in OAR chapter 411, division 323.
Other Standard *(specify)*:
Endorsement issued by the Department is also required for a certified service provider under OAR chapter 411, division 323 that has met the qualification criteria outlined in OAR 411-345-0010 - 411-345-0300.
Conditions that the Department may impose on an endorsement include but are not limited to:
1. Requiring additional staff or staff qualifications;
2. Requiring additional training;
For each specific geographic service area where services shall be delivered, a Medicaid Performing Provider Number assigned by the Department as described in OAR chapter 411,division 370.
Staff Qualifications:
1. Be at least 18 years of age;
2. Have approval to work based on current Department policy and procedures for background checks in OAR 407-007-0200 to 407-007-
0370 and OAR 411-323-0050(6) of this rule;
3. Be literate and capable of understanding written and oral orders
4. Be able to communicate with individuals, physicians, services coordinators, and appropriate others;
5. Be able to respond to emergency situations at all times;
6. Be certified in CPR and First Aid by a recognized training agency within 90 days of employment;
7. Receive six hours of pre-service training prior to supervising individuals including:
A. mandatory abuse reporting training,
B. training to work with individuals with developmental disabilities, and
C. training on the support needs of the individual to whom they will provide support;
8. Receive 12 hours of job-related in-service training annually;
9. Have clear job responsibilities as described in a current signed and dated job description; and
10. If transporting individuals, must meet applicable Oregon Driver and Motor Vehicle Services Division requirements, have a valid Oregon driver's license and proof of insurance.
11. Staff supporting an individual with a history of behavior requiring protective physical intervention must be trained by an instructor certified in OIS curriculum.
12. Any other specialized training as specified by contract requirements.
Verification of Provider Qualifications

Entity Responsible for Verification:
DHS
Frequency of Verification:
Initially and then every 5 years per OAR 411-323-0030.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Case Management
Alternate Service Title (if any):
Waiver Case Management

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Waiver Case Management is services furnished to assist individuals in gaining access to needed medical, social, educational and other services. Waiver Case Management includes the following assistance:
~Assessment and periodic reassessment of individual needs:
These annual assessment (more frequent with significant change in condition) activities include:
• Taking client history;
• Evaluation of the extent and nature of recipient's needs (medical, social, educational, and other services) and completing related documentation;
• Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
~Development (and periodic revision) of a specific care plan that:
• is based on the information collected through the assessment;
• specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
• includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

• identifies a course of action to respond to the assessed needs of the eligible individual.
~Referral and related activities:
To help an eligible individual obtain needed services including activities that help link an individual with:
• Medical, social, educational providers; or
• Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan such as making referrals to providers for needed services, and scheduling appointments for the individual.
~Monitoring and follow-up activities:

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

Waiver case management may include contact with non-eligible individuals, that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))
Providers maintain case records that document for all individuals receiving case management as follows:
(I) The name of the individual;
(ii) The dates of the case management services;
(iii)The name of the provider agency (if relevant) and the person providing the case management service;
(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services;
(viii) A timeline for reevaluation of the plan.
Providers of Waiver Case Management services are limited to employees of a Community Developmental Disabilities Program (CDDP), or other public or private agency contracted by a local community mental health authority or the Office of Developmental Disability Services (ODDS) Division.
• Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
• Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
• FFP only is available for case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Services Coordinator/Case Managers

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:
Services Coordinator/Case Managers
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Service Coordinators/Case Managers are employees of a Community Developmental Disabilities Program (CDDP), or employees of DHS, Office of Developmental Disability Services (ODDS), or other public or private agency, contracted by a local community mental health authority or ODDS.

The Service Coordinators/Case Managers must have knowledge of the public service system for developmental disability services in Oregon and at least:
~ a bachelor's degree in behavioral science, social science, or a closely related field; or
~ a bachelor's degree in any field AND one year of human services related experience; or
~ an associate's degree in a behavioral science, social science, or a closely related field AND two years human services related experience; or
~ three years of human services related experience.

Verification of Provider Qualifications
Entity Responsible for Verification:
CDDP
Frequency of Verification:
At time of initial employment and upon promotion of the case manager.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Direct Nursing

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 Direct Nursing service provides medically appropriate nursing services, to individuals 21 years of age and older as Private Duty Nursing State Plan services are available only to children up to age 21.*

Direct nursing services are direct shift nursing services for individuals with complex health management needs who meet all of the following:

• Require continuous but less than 24 hours-per-day nursing care on an ongoing long term basis;
• Meet established clinical criteria using the clinical criteria assessment form Direct Nursing Services Assessment;
• Because of the long term medical habilitation needs, do not qualify for state plan services;
• Have complex health management support needs for their medical condition based on a functional needs assessment:
• Require services determined medically necessary and appropriate based on physicians order; and
• Require a nursing care plan as defined in OAR 851-047-0010 that is reviewed every six months or if there is a significant change in their medical status.

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

Individuals who do not meet the clinical criteria requirements are not eligible for Direct Nursing services.
Other Limitations include:

• This service is not allowed in residential settings reimbursed through service element DD50. DD50 payments include the component of services and supports for an individuals assessed ADL, IADL, Medical, and Behavioral needs.
• Relatives providing Direct Nursing services must be qualified Medicaid Enrolled Providers and not in conflict with the Conflict of Interest Policy APD-PT-15-009.
• Direct Nursing services, for individuals 21 years of age and older, will be used after the State Plan home health nursing limits have been reached, or if the service required is different from that authorized under the State Plan.
• This service will not overlap, supplant, or duplicate other services provided through the Medicaid State Plan, other approved Medicaid waiver authorities, section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C 1401 et seq.).
• All Direct Nursing services must be prior authorized

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	A Self-employed Registered Nurse or Licensed Practical 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: Direct Nursing

Provider Category:
Individual

Provider Type:
A Self-employed Registered Nurse or Licensed Practical 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:
ODDS/OHA initially and ongoing

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: Direct Nursing

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:

ODDS/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: Direct Nursing

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:

ODDS/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: Service Specification

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

Service Type:

Other Service

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

Service Title:

Discovery/Career Exploration Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:

Discovery/Career Exploration is a person-centered, comprehensive employment planning and support service that provides assistance for individuals to obtain, maintain or advance in a competitive, customized or self-employment setting. Discovery/Career Exploration services may include:

• Discovery to identify an individual's interests, strengths, abilities, transferable skills and conditions for success both generally and relating to employment, with the goal of attaining and maintaining employment paid at minimum wage or higher in an integrated employment setting, including self-employment;
• Job and task analysis activities;
• *Review for need of assistive technology to promote increased independence in the workplace and if needs are identified a referral to the appropriate entity;
• Job shadowing;
• Informational interviewing (*The beneficiary must be present for informational interviews completed as a part of the Discovery service);
• Employment preparation (i.e. resume development, work procedures);
• Volunteerism to assist the person in identifying transferable skills and job or career interests.

The outcome of this service is: 1) the development of a Discovery Profile, which provides employment-related information essential to the development of, or revision of, an individual's employment-related planning document, and 2) *a referral to vocational rehabilitation services is expected, but not required for an outcome payment to occur.

Any of the above service components may be provided to someone considering or seeking employment, as well as someone who is already employed but who wishes to advance in his/her career or change careers.

Discovery/Career Exploration services should be reviewed and considered as a component of an individual's ISP no less than annually and more frequently as necessary or as requested by the individual. The presumption in considering these services is that all individuals eligible for services under this waiver are capable of working in an integrated employment setting and earning at least minimum wage. Consistent with the person-centered approach to these services, individuals should be encouraged, on an ongoing basis, to explore their interests, strengths, and abilities relating to integrated employment. Services and supports should be designed to support successful employment outcomes consistent with the individual's personal and career goals.

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

The individual's employment team, including the ISP team and representatives from vocational rehabilitation services, must monitor the Discovery service to ensure the work is adequate and complete. If the service is incomplete, the individual and his or her ISP team can request additional Discovery related activities. In more serious cases where the service is inadequate, the individual and his or her ISP team can request a different Discovery provider. Discovery cannot be billed if the service or Discovery Profile are inadequate or incomplete as determined by the ISP team.
***Personal care/assistance may be a component of Discovery/Career Exploration services, but may not comprise the entirety of the service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Discovery/Career Exploration services must be completed within a three-month period with a three month extension for legitimate cause upon ODDS approval.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Discovery/Career Exploration Services Provider
Agency	Discovery/Career Exploration Services Agency

Appendix C: Participant Services

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

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

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

Certificate *(specify)*:

Other Standard *(specify)*:
(a) Maintain a drug-free work place;

(b) Be at least 18 years of age;

(c) Have approval to work based on a background check completed by the Department as described in OAR 407-007-0200 to 407-007-0370 and section (7) of this rule, and be free of convictions or founded allegations of abuse by the appropriate agency including, but not limited to, the Department, CDDP, CIIS, or Support Services Brokerage;

(d) Not have been convicted of any of the disqualifying crimes listed in OAR 407-007-0275, unless hired or contracted with prior to July 28, 2009 and remaining in the original position for which the independent worker was hired or contracted for;

(e) Be legally eligible to work in the United States;

(f) may not provide or deliver services to their spouse.

(g) Demonstrate by background, education, references, skills, and abilities that the personal support worker is capable of safely and adequately performing the tasks specified in an ISP, with such demonstration confirmed in writing by an individual or the representative of the individual, including:

(A) Ability and sufficient education to follow oral and written instructions and keep any required records;

(B) Responsibility, maturity, and reputable character exercising sound judgment;

(C) Ability to communicate with the individual; and

(D) Training of a nature and type sufficient to ensure that the independent worker has knowledge of emergency procedures specific to the individual;

(h) Maintain confidentiality and safeguard individual information. Unless given specific permission by an individual or the representative of an individual, the independent worker may not share any personal information about the individual, including medical, social service, financial, public assistance, legal, or interpersonal details;

(i) Not be on the list of excluded or debarred providers maintained by the Office of the Inspector General (http://exclusions.oig.hhs.gov/);

(j) Complete and submit a Provider Enrollment Agreement to the Department and possess a current provider number issued by the Department;

(k) Have a tax identification number or social security number that matches the legal name of the independent worker, as verified by the Internal Revenue Service or Social Security Administration; and

(l) If providing in-home services requiring professional licensure, possess a current and unencumbered license. The individual, representative of the individual, Department, CDDP, CIIS, or Support Service Brokerage must check the license status to verify the license is current and unencumbered.

(m) Any other competencies or training as required by the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:
FMS, Participant or designated representative.

Frequency of Verification:
Upon initial enrollment as a service provider and at request of participant or designated representative.

All employment service providers are subject to the same competency-based training, qualification, and credentialing requirements. This information is verified annually by the Service Coordinators and Personal Agents who authorize the Employment Service during the person centered planning process. It is also verified through both ODDS and Employment First Quality Assurance reviews.

Additionally, ODDS currently conducts criminal background checks and verifies other qualifications for independent providers every two years when provider enrollment agreements are completed.

If an independent contractor or other Personal Support Worker (PSW), subject to the Collective Bargaining Agreement (CBA), is providing an employment service, the Oregon Home Care Commission (OHCC) will coordinate with ODDS to verify training requirements are met. This verification will occur no less than every two years. **

Appendix C: Participant Services

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

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

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

Certificate *(specify)*:
OAR 411-340-0010 through 411-340-0180 or
Certificate issued by the Department to a service provider that certifies the service provider is eligible under the rules in OAR chapter 411, division 323.
Other Standard *(specify)*:
chapter 411, division 323 that has met the qualification criteria outlined in OAR 411-345-0010 - 411-345-0300.
Conditions that the Department may impose on an endorsement include but are not limited to: 1. Requiring additional staff or staff qualifications;
2. Requiring additional training;
For each specific geographic service area where services shall be delivered, a Medicaid Performing Provider Number assigned by the Department as described in OAR chapter 411, division 370.
Staff Qualifications:
1. Be at least 18 years of age;
2. Have approval to work based on current Department policy and procedures for background checks in OAR 407-007-0200 to 407-007-0370 and OAR 411-323-0050(6) of this rule;
3. Be literate and capable of understanding written and oral orders
4. Be able to communicate with individuals, physicians, services coordinators, and appropriate others;
5. Be able to respond to emergency situations at all times;
6. Be certified in CPR and First Aid by a recognized training agency within 90 days of employment;

7. Receive six hours of pre-service training prior to supervising individuals including:
A. mandatory abuse reporting training,
B. training to work with individuals with developmental disabilities, and
C. training on the support needs of the individual to whom they will provide support;
8. Receive 12 hours of job-related in-service training annually;
9. Have clear job responsibilities as described in a current signed and dated job description; and
10. If transporting individuals, must meet applicable Oregon Driver and Motor Vehicle Services Division requirements, have a valid Oregon driver's license and proof of insurance.
11. Staff supporting an individual with a history of behavior requiring protective physical intervention must be trained by an instructor certified in OIS curriculum
12. Any other specialized training as specified by contract requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHS

Frequency of Verification:
Initially and then every 5 years per OAR 411-323-0030.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Environmental Safety Modifications

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:
Those physical adaptations to the exterior of a participant's private residence or the participant's family, required by the service plan, that are necessary to ensure the health, welfare and safety of the participant or that

enable the participant to function with greater independence around the home.
Such adaptations typically include the installation of fencing, or pathways. Materials must be of the most cost effective type and decorative additions will not be considered. Modifications will not include additions that are non-essential to meeting the purpose of a goal stated in the service plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Environmental Safety Modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
Fencing will be limited to 200 linear feet without approval from DHS to exceed the limit. Large gates such as automobile gates are excluded. Costs for paint and stain are excluded.
Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence to accommodate a wheelchair). Also excluded are adaptations or improvements available under the state plan.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Safety Modifications

Provider Category:
Individual
Provider Type:
Vendors
Provider Qualifications
License *(specify):*
have a retail business license.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
CDDP
Frequency of Verification:
Prior to authorization of service and payment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Family Training - Conferences and Workshops

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):*

Training services for family members who provide unpaid support, training, companionship and/or supervision to participants who self-direct their own services.

For purposes of receipt of this service, "family" is defined as a unit of two or more persons that include at least one person with developmental disabilities where the primary caregiver(s) is (are):

(a) Related to the individual with developmental disabilities by blood, marriage or legal adoption; or

(b) In a domestic relationship where partners share:

(A) A permanent residence;

(B) Joint responsibility for the household in general (e.g. child-rearing, maintenance of the residence, basic living expenses); and

(C) Joint responsibility for supporting a member of the household with disabilities related to one of the partners by blood, marriage, or legal adoption.

This service may not be provided in order to train paid caregivers.

Training to family members includes:

-instruction about treatment regimens and other services included in the service plan;

-instruction about the use of equipment specified in the service plan; and/or

-information and education about the individual's disability, health and medical conditions, and includes updates as necessary to increase the family's capability to care for their family member and safely maintain the participant at home.

Family Training may include attendance at conferences or group training.

Training and counseling furnished to family members who provide uncompensated care and support to the participant must be directly related to their role in supporting the participant in areas specified in the service plan. Family Training services for family members who provide unpaid supports to the participant must be included in the ISP.

Family Training and Counseling supports do not duplicate any other Medicaid State Plan or waiver service. FFP is available for the costs of registration and training fees associated with formal instruction in areas relevant to participant needs identified in the service plan. FFP is not available for the costs of travel, meals and overnight lodging to attend a training event or conference.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Health Educator: Organized Conferences and Workshops

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training - Conferences and Workshops

Provider Category:

Individual

Provider Type:

Health Educator: Organized Conferences and Workshops

Provider Qualifications

License *(specify)*:

N/A

Certificate *(specify)*:

N/A

Other Standard *(specify)*:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

CDDP

Frequency of Verification:

Prior to authorization of service and payment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Financial Management Services

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)*:

**Service/function that assists the family or participant to facilitate the employment of staff by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll, withholding Federal, state, and local tax and making tax payments to appropriate tax authorities, and issuing union dues to an employee union, if applicable.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Financial Management Services

Provider Category:
Agency
Provider Type:
Financial Management Services Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Providers must be an IRS-approved Fiscal/Employer Agent and be able to demonstrate an extensive understanding of the myriad of state and federal tax and employment laws that govern this select group of employers. A minimum of 10 years of experience in payroll and tax related matters for individuals with intellectual/developmental disabilities, with demonstrated experience in the following services:
IRS form SS-4 (Apply for EIN)
• IRS form 2678 (Appointment of FI)
• IRS form 8821 (Permission to Communicate/File)
• State Specific Employer Registration
• Employer Change in Status Forms
• State Specific Tax Information Authorization
• IRS form W-5 (Earned Income Credit)
• IRS form W-4
• IRS form W-2
• File IRS form 940 (Employer annual FUTA return)
• File IRS 941 (Employer quarterly tax return)
• State Income Tax Witholding Returns
• Processing Payroll based on approved employee timesheets
• Withholding and paying FICA (Employer)
• Withholding and paying FICA (Employee)
• Withholding/Paying State Income Tax
• Withholding/Paying Federal Income Tax
• Withholding and Remitting Garnishments/Levies/Liens
• Paying Employees
• Direct Deposit
• Withholding/Paying Local Taxes
• Refunding/Applying overpayment of taxes
• Distribute and File W-2's
• Maintaining payroll tax records in accordance with state and federal laws
• Assist with Policy and Procedure Manuals
• Staying Up to Date on IRS and State Tax law
• Renew IRS form 8821
• Retiring EIN
• Retiring State Specific ID Numbers

Verification of Provider Qualifications
Entity Responsible for Verification:
DHS
Frequency of Verification:
Initially and then every 5 years per OAR 411-323-0030.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Supplies

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)*:

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

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

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

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

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

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	Vendors / Medical Supply Companies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Supplies

Provider Category:
Individual

Provider Type:
Vendors / Medical Supply Companies

Provider Qualifications

License *(specify):*
Supplies only: have a retail business license.

Certificate *(specify):*

Other Standard *(specify):*
Specialized medical supplies will be obtained from authorized vendors.

Verification of Provider Qualifications

Entity Responsible for Verification:
CDDP

Frequency of Verification:
Prior to authorization of service and payment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Supported Employment - Small Group Employment Support

HCBS Taxonomy:

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

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

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

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

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

Personal care/assistance may be a component of Small Group Employment Support services, but may not comprise the entirety of the service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Small group employment support does not include vocational or employment path services provided in facility based work settings.
This Service does not include support for volunteering.
This service does not include payment for supervisory activities rendered as a normal part of the business setting.
An individual may receive any combination of Small Group Employment Services, and Employment Path Services, the total of which (including any Supported Employment - Individual Employment services received) shall not exceed an annual average of 108.5 hours per month.
The waiver will not cover services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). This service will not overlap with, supplant,or duplicate other services provided through the waiver or Medicaid state plan services. Documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **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	Small Group Employment Provider
Agency	Small Group Employment Agency

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Small Group Employment Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
(a) Maintain a drug-free work place;

(b) Be at least 18 years of age;

(c) Have approval to work based on a background check completed by the Department as described in OAR 407-007-0200 to 407-007-0370 and section (7) of this rule, and be free of convictions or founded allegations of abuse by the appropriate agency including, but not limited to, the Department, CDDP, CIIS, or Support Services Brokerage;

(d) Not have been convicted of any of the disqualifying crimes listed in OAR 407-007-0275, unless hired or contracted with prior to July 28, 2009 and remaining in the original position for which the independent worker was hired or contracted for;

(e) Be legally eligible to work in the United States;

(f) may not provide or deliver services to their spouse.

(g) Demonstrate by background, education, references, skills, and abilities that the personal support worker is capable of safely and adequately performing the tasks specified in an ISP, with such demonstration confirmed in writing by an individual or the representative of the individual, including:

(A) Ability and sufficient education to follow oral and written instructions and keep any required records;

(B) Responsibility, maturity, and reputable character exercising sound judgment;

(C) Ability to communicate with the individual; and

(D) Training of a nature and type sufficient to ensure that the independent worker has knowledge of emergency procedures specific to the individual;

(h) Maintain confidentiality and safeguard individual information. Unless given specific permission by an individual or the representative of an individual, the independent worker may not share any personal information about the individual, including medical, social service, financial, public assistance, legal, or interpersonal details;

(i) Not be on the list of excluded or debarred providers maintained by the Office of the Inspector General (http://exclusions.oig.hhs.gov/);

(j) Complete and submit a Provider Enrollment Agreement to the Department and possess a current provider number issued by the Department;

(k) Have a tax identification number or social security number that matches the legal name of the independent worker, as verified by the Internal Revenue Service or Social Security Administration; and

(l) If providing in-home services requiring professional licensure, possess a current and unencumbered license. The individual, representative of the individual, Department, CDDP, CIIS, or Support Service Brokerage must check the license status to verify the license is current and unencumbered.

(m) Any other competencies or training as required by the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:

FMS, Participant or designated representative.

Frequency of Verification:

Upon initial enrollment as a service provider and at request of participant or designated representative.

All employment service providers are subject to the same competency-based training, qualification, and credentialing requirements. This information is verified annually by the Service Coordinators and Personal Agents who authorize the Employment Service during the person centered planning process. It is also verified through both ODDS and Employment First Quality Assurance reviews.

Additionally, ODDS currently conducts criminal background checks and verifies other qualifications for independent providers every two years when provider enrollment agreements are completed.

**If an independent contractor or other Personal Support Worker (PSW), subject to the Collective Bargaining Agreement (CBA), is providing an employment service, the Oregon Home Care Commission (OHCC) will coordinate with ODDS to verify training requirements are met. This verification will occur no less than every two years.

Appendix C: Participant Services

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

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

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
DHS
Frequency of Verification:
Initially and then every 5 years per OAR 411-323-0030.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The following are specifically excluded:

1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;
2. Purchase or lease of a vehicle; and
3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

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

The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Individual
Provider Type:
Vendors
Provider Qualifications
License *(specify)*:
have a retail business license.
Certificate *(specify)*:

Other Standard *(specify)*:
Bonded and insured
Verification of Provider Qualifications
Entity Responsible for Verification:
DHS
Frequency of Verification:
Prior to authorization of service and payment

Appendix C: Participant Services

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

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

- ( ) **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- (•) **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - [x] **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:

Community Developmental Disabilities Program (CDDP).

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 Statutes and Oregon Administrative Rules 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 oversee, live or work closely with, or provide services to vulnerable people. OAR states that DHS conducts, or requires contractors to conduct, such criminal records checks on persons identified as "Subject Individuals" which include:
(A) An employee of DHS, person who has been offered employment by the Department, volunteer or student over whom DHS has direction and control.
(B) A person who is licensed, certified, registered or otherwise regulated or authorized for payment by DHS and who provides care.
(C) An employee or volunteer who provides care within any entity or agency licensed, certified, registered or otherwise regulated by DHS.
(D) A direct care staff person secured through the services of a personnel services or staffing agency who works in any long term care facility licensed by the Department pursuant to ORS chapter 441.
(E) Except as provided in rule, a person who lives in a facility that is licensed, certified, registered or otherwise regulated by DHS to provide care.
(F) An individual working for a private, licensed child caring agency or system of care contractors providing child welfare services pursuant to ORS chapter 418.
(G) A homecare worker, personal care services provider or an independent provider employed by a DHS client and who provides services to the client if DHS helps to pay for the services.
(H) A childcare provider reimbursed through DHS's child care program, and employees and other persons in child care facilities that are exempt from certification or registration by the Child Care Division of the Employment Department. This includes all persons who reside in or who are frequent visitors to the residence or facility where the child care services are provided and who may have unsupervised access to the children. (REF: OAR chapter 461, division 165.)
(I) A contact person or authorized designee as defined in OAR.
(J) A person providing training to staff within a long term care facility.
(K) Any person serving as an owner, operator or manager of a room and board facility pursuant to OAR chapter 411, division 68.
(L) Any person applying for a paid or volunteer position, any employee, any volunteer, any contractor, or any employee of any contractor of a State-operated group home within DHS's State-Operated Community Programs and Oregon State Hospital.
(M) Notwithstanding subsection (27)(b) of the rule, any person who is required to complete a criminal history check pursuant to a contract or written agreement with DHS or by other Oregon Administrative Rules of DHS, if the requirement is within the statutory authority granted to the Department. Specific statutory authority must be specified in the contract.

(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 may require a national search using fingerprints and the FBI database under several circumstances, e.g.: out-of-state residency for 60 or more consecutive days during the previous three years; indication of criminal history outside Oregon; or there is some question of identity or history. 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). Criminal background screenings are typically conducted prior to execution of provider agreements and at intervals thereafter based on rules for the service provided and at any time DHS has reason to believe that re-screening is required.

(c) Process for ensuring mandatory investigations have been conducted according to policy. The DHS Criminal Records Unit (CRU) has developed standard forms and processes to initiate and conduct criminal background screening. The CRU approves all persons authorized by DHS ("authorized designees") to conduct screenings based on criminal background checks and satisfactory completion of CRU-provided training on standard forms, processes, information sources and implications, and factors to consider in weighing tests. Additionally, provider payment is linked to continued compliance with criminal history review standards, e.g.:
~ Local CDDP workers authorize payment to direct care providers based on initial fitness determination and must enter re-approval at prescribed intervals or provider payment is suspended; and
~ Licensed provider enrollment payment is suspended when license expires unless DHS worker enters information that license has been renewed. Licensing process involves sampling personnel files for evidence criminal background review and fitness determinations according to DHS policy.

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):

DHS Child Welfare maintains a child abuse registry of individuals with founded allegations of child abuse/child neglect per Oregon Revised Statutes governing child abuse. All potential providers for children are checked against the Child Welfare abuse registry. This is completed with all new applicants or when a provider license is renewed. DHS personnel, who are trained and granted access to the DHS mainframe screens that contain the registry, conduct the screening against the registry. This screening is done as part of the criminal history check (CHC) process. Applicant's whose background check contains a founded allegation of child abuse as made by DHS Child Welfare may not be licensed or employed to work with children unless the applicant successfully appeals the basis for the determination.
Child Welfare Abuse Registry is only used for children.
Oregon Administrative Rules that govern DHS' children's developmental disabilities services contain provisions that require a child abuse background check as part of the provider fitness determination. The OARs also define the frequency of the required background checks and explain the outcome of a having a founded allegation on the applicant's record. The CHC consent form includes authorization for the abuse background check requirement. The fitness determination notice is given to DHS, DD Licensing Unit or the applicant's potential employer so a denial of licensing/certification or employment can be issued. Upon denial of licensing/certification or employment based on information found in the registry, the applicant is informed of their appeal rights and instructed to contact DHS Child Welfare for specific information on the appeal process. The determination remains in effect as long as the founded allegation remains in the registry. Licensing tracks all denials and adverse actions in a database.
A renewal report is generated monthly showing the expiration date of each site. The report is maintained by program type and then by county. Licensing staff assigned to these programs is responsible for scheduling and completing the review prior to the expiration date. Managers and lead workers monitor to ensure that inspections are completed and licenses are renewed in a timely manner.

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	
Non-Relative Adult Foster Care and Children's Developmental Disability Foster Care	
Adult Group Homes and Children's Group Homes	

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.

~ Non-Relative Adult Foster Care and Children's Developmental Disability Foster Care:
Foster Care Homes are responsible for providing up to 24 hours of care, supervision, and training to individuals with developmental disabilities. Services provided in a Foster Home include assistance with Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL) and other health-related tasks, provided under the Medicaid State Plan. Additional services provided in a Foster Home include assisting individuals to access other community resources that increase their integration and independence and are provided through a combination of waiver and State Plan services.
Services are provided in a family-type home, but not the home of a parent, guardian, or family member. Services are provided in settings of five or fewer individuals in care in a single home and must be appropriate to the needs, preferences, age and condition of the individual residents. These homes are generally indistinguishable from their neighbors in communities throughout the state. Cooking, dining, and common areas are typical in scale and use of family homes in the area, with access limited only by specific individual resident safety concerns. No more than two residents share a bedroom. Assistance with ADLs is conducted privately. Residents associate and communicate privately with any person of choice. Providers are required to make available at least six hours of activities each week oriented to individual interests, not including television and movies. Residents also have access to, and participate in, activities of chosen social, religious and community groups.
For children eligible for IV-E, room, board and basic supervision is funded with Title IV-E funds. For children not eligible for IV-E, and for adults, Social Security or other income sources pay for room and board.

~ Adult Group Homes and Children's Group Homes:
Residential facilities in the community designed to provide 24-hour supervised care, training and support for individuals with developmental disabilities. Group homes can vary in the number of individuals who live there and the number of staff, depending on the support needs of the individuals. There are some group homes designed to serve individuals with complex medical needs, as well as those with challenging behavioral needs.
Most group homes are operated by private, non-profit agencies, while some group homes are operated by the State (State Operated Community Programs (SACU)).
All individuals living in a group home must have an Individual Support Plan (ISP). This is a comprehensive plan that outlines the type of training, and level of support and supervision needed to help an individual live as safely and as independently as possible.
Services must be appropriate to the needs, preferences, age and condition of the individual residents. These homes are generally indistinguishable from their neighbors in communities throughout the state. Cooking, dining, and common areas are typical in scale and use of family homes in the area, with access

limited only by specific individual resident safety concerns. No more than two residents share a bedroom. Assistance with ADLs is conducted privately. Residents associate and communicate privately with any person of choice. Providers are required to make available at least six hours of activities each week oriented to individual interests, not including television and movies. Residents also have access to, and participate in, activities of chosen social, religious and community groups.
Room and Board is funded by an individual's Social Security or other income source and is not paid using TXIX funds.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Non-Relative Adult Foster Care and Children's Developmental Disability Foster Care

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Direct Nursing	☐
Family Training - Conferences and Workshops	☐
Waiver Case Management	☑
Employment Path Services	☑
Discovery/Career Exploration Services	☑
Supported Employment - Individual Employment Support	☑
Financial Management Services	☐
Environmental Safety Modifications	☐
Vehicle Modifications	☐
Supported Employment - Small Group Employment Support	☑
Specialized Medical Supplies	☑

Facility Capacity Limit:

Five or fewer individuals with ID/DD who are not related to the provider by blood or marriage.

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	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	

Standard	Topic Addressed
	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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:

Adult Group Homes and Children's Group Homes

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Direct Nursing	☐
Family Training - Conferences and Workshops	☐
Waiver Case Management	☑
Employment Path Services	☑
Discovery/Career Exploration Services	☑
Supported Employment - Individual Employment Support	☑
Financial Management Services	☐
Environmental Safety Modifications	☐
Vehicle Modifications	☐
Supported Employment - Small Group Employment Support	☑
Specialized Medical Supplies	☑

Facility Capacity Limit:

The vast majority of residential settings have a capacity of 5 or fewer residents who are ID/DD and are not related to the provider by blood or marriage. A few settings range from 6 to 20 residents.

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	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑

Standard	Topic Addressed
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

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.*

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 provide specified waiver services and are required to meet the same qualifications set forth in Appendix C-1/C-3 and Oregon Administrative Rule. Relatives/legal guardians who are identified as providers in the service plan are verified as being in the best interest of the consumer by the participant, legal representative, or designated representative, and personal agent. Anyone identified as a provider, including relatives/legal representatives cannot be responsible for directing ISP development. When a legal guardian is paid to be a provider of waiver services, another person must be delegated to act as a representative for the purpose of developing an ISP.

All providers, including relatives/legal guardians, work under signed service agreements that specify the services to be provided. Time sheets and/or invoices that describe the service provided are verified by the participant or representative or may be confirmed by the Personal Agent. No providers, including relatives/legal guardians, may sign off on their own time sheets or invoices showing the hours worked.

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

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

○ **Other policy.**

Specify:

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

There is no specific open or closed period for provider enrollments. Providers are enrolled on an as needed, employed or contracted basis. If a CDDP requests potential providers, there may be time frames listed within that specific request, but those would be limited to that specific request. There are different qualifications for providers, depending on the type of service the provider is set up to provide.
Any individual or agency can enroll to become a provider of waivered services at any time, providing that they can meet all the necessary and required actions as stipulated by Oregon Revised Statutes, Oregon Secretary of State, Oregon Administrative Rules, and/or other criteria required to become a provider for the type of Medicaid services they wish to provide. This applies to individual contractor as well as agency providers.
In many instances potential or existing providers will approach a local CDDP to begin providing services in that area or expand the services they are already providing. However, becoming a qualified provider does not ensure placement of individuals in their services by the CDDP.
Provider enrollments for services may be developed or recruited to provide services to a specific individual, or through a Request for Qualifications (RFQ) or Request for Proposal (RFP) process.
On average, it takes the Licensing Unit 30 days or less to issue a license or certification to a brand new provider when the provider has submitted all the relevant information and has met all the requirements of a new provider. In the expansion of new sites by an existing provider it will generally take one week to two weeks to issue a license or certificate, again, depending on the provider's preparedness. This timeframe applies to all licensed or certified program types.
Provider training requirements are outlined in the OAR applicable to the service provided. When a provider is licensed or certified by DHS, the licensing/certification review process verifies training of a provider's employees. DHS offers guidance and instruction to potential providers on its website. The website address is http://www.oregon.gov/DHS/spd/provtools/index.shtml. Potential providers and current providers may review rate setting manuals, worker guides, rules and regulations, and various other resources and tools.

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

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

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

	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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):*
	☐ **Weekly**	☐ **100% Review**

☑ **State Medicaid Agency**		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 non-licensed/non-certified providers who adhere to waiver requirements D: Total number of newly enrolled non-licensed/non-certified providers reviewed

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

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

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):*
	☐ **Weekly**	☐ **100% Review**

☑ **State Medicaid Agency**		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: HA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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: Number and percent of enrolled providers who meet training requirements ongoing N: Number of enrolled providers who meet training requirements ongoing D: Total number of providers reviewed

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Data and reports gathered and created by DHS staff during quality reviews is reviewed and analyzed on a continuous and ongoing basis by the OHA liaison to DHS to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Upon completion of OHA' analysis and review of DHS' quality assurance data and reports, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the MOCSC. The Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) annually reviews the reports and document DHS and OHA remediation efforts. A Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) for OHA and DHS meet at least twice per year to review Medicaid/CHIP-related policy. The Steering Committee will be comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of policy-related issues and delineation of responsibilities, including establishment of a strategic plan for the two agencies. A Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) for OHA and DHS meet 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 MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and DHS. DHS staff address individual problems with 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 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. Non-compliance will be determined by any performance measure that falls below 86% accuracy.
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)
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*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

"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:
Individual Support Plan (ISP)

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
   - ☐ **Registered nurse, licensed to practice in the State**
   - ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
   - ☐ **Licensed physician (M.D. or D.O)**

- [x] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- [ ] **Social Worker**
  Specify qualifications:
- [ ] **Other**
  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) - Oregon Administrative Rule (OAR) establishes standards for the development of service plans for individuals with intellectual and/or developmental disabilities. These plans are called Individual Support Plans (ISPs). At a minimum, ISPs address the individual's assessed functional support needs; personal control and family participation; service choice and preference; barriers; health and safety risks, and support protocols.

ISP teams are comprised of people who care about and know the individual. The individual is present, is encouraged and assisted to participate in every aspect of their service planning as fully as they are able and choose to do so. Services Coordinator, legal guardians and other participants chosen by the individual (e.g. representatives, family members, providers of service, advocate, specialist, and/or any relevant consultant) participate in the ISP process or parts of the ISP process. Participation includes sharing information to assist with the functional needs assessment and identification of health and safety risks; indicate service preferences; helping plan for the future and contributing to supports that will help the individual have the life he/she wants; reviewing and approving the ISP and other documents by signing the ISP; communicating objections to the ISP; and approving changes or modifications to the ISP or support documents throughout the year, if needed.

(b) - The individual's authority to determine who is included in the ISP process is described in both OARs and in the

State approved ISP Manuals.

The OARs discuss team composition and the individual's authority for determining who is included in the process, for example:
~ membership on ISP teams must, at a minimum, conform to all relevant rules;
~ family participation is encouraged, unless refused by the individual receiving services or by the guardian of an adult or child receiving services;
~ the individual may request additional participants, chosen representatives, friends or significant others;
~ the individual may raise an objection to a particular person participating in their service planning process. When an individual raises objections to a person on the ISP team, the ISP team must attempt to accommodate the objection.

The ISP Manuals, available upon CMS' request, discuss the role of the individual for whom the plan is being developed. One element (among many) is the responsibility for the individual to identify who he/she would like to attend and participate in their ISP meeting.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) - All individuals receiving services are required to have an individualized plan of care or service plan. In Oregon these plans are called Individual Support Plans (ISPs). The ISP is a holistic service plan that includes all components, strategies and protocols needed to address the individual's service and support needs identified by the functional needs assessment, what is important to and for the person, other information provided, client preferences and choice. The plan also includes the type of service to be received, under what Medicaid authority the service is being delivered, the amount, duration, frequency, provider type and cost.

The ISP is developed, reviewed and updated during a face-to-face ISP meeting. ISP meetings are held at least annually, or more frequently as needed due to changes in support needs or as requested by the individual.

The individual receiving services and the people they have selected to be part of his/her ISP team participate in the ISP development process. The ISP planning and development process is facilitated by the individual's service coordinator. Using information provided by the ISP team members, service coordinator is ultimately responsible for completing the ISP, including conducting the individual's functional needs assessment; gathering information on the individual's personal choices and preferences; indentifying significant health care, mental health or behavioral needs and related necessary supports based on the functional needs assessment; defining financial supports, safety skills and support needs. The ISP process is built on a foundation of person-centered planning, and is thoroughly described by the ISP Manuals and referenced in OARs.

ISPs must be developed and implemented before the delivery of any TXIX Medicaid service. ISP meetings must occur within 60 days of the individual's initial functional needs assessment and Level of Care (LOC) determination or annual redetermination. If a transitional ISP is utilized, a formal ISP must be developed and implemented within 60 days of that transitional ISP.

If changes or updates to the ISP are needed, the service coordinator is responsible for documenting those changes and updating the ISP. The service coordinator shall assure distribution of the ISP to all ISP team members within 30 calendar days of the ISP team meeting(s).

(b) - Oregon uses functional needs assessments to identify service needs that are then addressed in the ISP. There

are a variety of additional tools utilized to support the functional needs assessment in identifying other pertinent information regarding an individual, their preferences and choices. These in combination are all used in the development of the individual's ISP.

In terms of service delivery venue, an individual may choose to receive services and supports that enable them to reside in their own home or the home of a family member. Individuals may choose to receive their services in a community-based service facility. The individual's choice of service delivery venue determines the functional needs assessment and supporting informational tools utilized to assist in developing the corresponding ISP.

For individuals residing in their own or family home, the tools may include:
~ In-Home Services for Adults Goals and Needs Survey;
~ Supported Living Assessment;
~ In-Home Services Needs Assessment for Children;
~ Additional information related to the individual's health and medical, safety, dietary, financial, social, leisure, mental health and behavioral support needs and preferences;

For individuals residing in community-based services facilities, the assessments and other supporting tools utilized may include a combination of the following:
~ the Supports Intensity Scale (SIS) Assessment;
~ the Support Needs Assessment Profile (SNAP):
~ Personal Focus Worksheet (PFW);
~ Risk Tracking Record (RTR);
~ Other Support Documents and Protocols; When a new significant risk is identified, a corresponding support document tool must be developed and implemented.
~ ISP Agenda.

(c) – At the initial application for waiver services and LOC determination, the individual is given the choice between institutional or community-based care for delivery of their services.

During the annual ISP development and meeting process, the service coordinator shall notify the individual or guardian of the services available under TXIX Medicaid, and document the individual or guardian's choice of service(s). In addition, throughout the ISP process there are many opportunities when the range of services may be offered and explained.

Service coordinators also offer the individual and the guardian information regarding complaints, Medicaid Fair Hearing rights and the Administrative Review process annually. This is frequently completed at the time of the annual ISP meeting. Furthermore, the service coordinator will inform the individual and/or guardian about ways in which to identify and report abuse, neglect and exploitation annually.

(d) - All activities and tools that precede the actual ISP meeting are designed to reflect a person's interests, desires, choices and preferences as well as specific health, financial, safety and other support needs identified on the applicable functional needs assessment tools. The ISP is the written detail of the support strategies and activities needed to meet the individual's identified service and support needs. Oregon requires the use of a "Person-Centered Planning Process" to gather support need information. The process is designed to maximize individual participation in making choices, identifying needs and priorities, strengths, relationships, and resources, and reflects what is important to and for an individual. It helps the individual and their ISP team to strengthen naturally occurring opportunities for support at home and in the community. The ISP results in strategies, services and supports that reflect what is most important to and most important for the individual in his/her daily life, while supporting their identified service needs.

(e) - The ISP process is designed to coordinate waiver and other services. Through the tools and the established process for developing the ISP, functional support needs, health risks, safety issues, and preferences are assessed and discussed. The ISP and other tools may identify the need to develop support documents that outline protocols for an individual's specific health, safety or support need(s), possibly resulting in the acquisition of other Medicaid services or specialists becoming involved with the individual. The ISP documents any action needed and who is responsible. Service coordinators, as part of Waiver Case Management, are responsible for monitoring the individual's services to assure that the ISP is implemented and that waiver and other services are coordinated, provided and meet the individual's service and support needs identified in the ISP.

(f) - The ISP articulates decisions and agreements made as a result of using a person-centered process of information gathering and planning. The functional assessments and documents that are a part of the ISP process define desires and needed supports of the individual. While some roles and responsibilities are stipulated in the OARs and other CMS regulations, through the ISP team meeting, responsibilities for implementing the plan are discussed and assigned. Service delivery providers, the individual, service coordinator, family members, friends and other natural supports are all likely to assume some responsibility in the plan's implementation.

OARs state that service coordinators hold the responsibility of conducting assessments, developing the ISP, coordinating and monitoring services delivered to an individual. The OARs specifies a minimum frequency of monitoring of services. The CDDP can choose to monitor more frequently than OAR requirements, as an individual's needs indicate.

(g) The ISP is considered to be a "living" document, and should be changed and updated as an individual's support needs or preferences change. Any member of the individual's ISP team, including the individual, can request a meeting to review changes in preference or need. This may prompt the review of the functional needs assessment or other supporting documents and tools, including updating them with new or additional information as indicated. If a change to the individual's ISP is made, it must be documented by service coordinator on the appropriate ISP change or addendum forms, which documents the specific change(s) being made, the reason for the change(s), where the change will be documented, and ISP team review and approval of the change(s). The service coordinator shall ensure distribution of the updated ISP to all ISP team members within 30 calendar days of the ISP team meeting(s).

Referenced OARs and ISP manuals are available upon request.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The various functional needs assessments and additional informative tools are designed to identify significant risks that are present for the individual receiving services. Based upon the answers given for an individual for specific functional support need area, the tools prompt the assessor that a potential risk has been identified and that additional supports (such as health support protocols, a nursing care, a behavior support plan, etc.) may be necessary to address that risk.

Another informational tool - the Risk Tracking Record (RTR) - also identifies serious and significant risks to the individual. The RTR provides critical information about the support needs a person has with regard to health, medical, safety/financial, and behavior/mental health risks, and directs the development of protocols for such risks. Every risk identified by the RTR must be addressed in a support document or protocol. The protocols provide specific information on how to support an individual in mitigating the risks (for example: description of risk preventions; signs and symptoms; risk intervention strategies and protocols).

Some support document formats are required by the State and others can be designed to meet the unique needs of the individual. The six support documents with a State-required format are the Aspiration/Choking Protocol, Constipation Protocol, Dehydration Protocol, Seizure Protocol, PICA Protocol, and the Financial Plan.

If the risk falls outside of the issues listed above, the team may choose the type of document to use to address the risk. Examples include: Staff Guidelines, Dining Plan or Protocol, or Interaction Guidelines. Again, support documents must outline information needed to support the individual and must include a set of preventative measures to minimize the risk.

The Financial Plan is required for every individual that needs any support in independently managing his/her finances.

Additional support documents include a Safety Plan and a Behavior Support Plan. These do not use a State-required format.

A Safety Plan is the support document used to address various safety issues for the individual being supported. While there is no State required format for this plan, there are required elements. Every Safety Plan must include a description of the risk it is addressing, what preventative measures are in place to minimize this risk, the author's name and the date of the document. Safety Plans are written for specific locations; an individual's Safety Plan for their home cannot be used for their location of work, and vice versa.

A Behavior Support Plan (BSP) is a support document used when interventions are needed for identified behavioral risks. The ISP team makes the decision to create a BSP. A BSP outlines strategies to ensure the safety of the individual and others through positive supports when the individual engages in dangerous behaviors, and must be written in accordance with current Oregon Intervention System (OIS) practices and follow OARs specific to the service being provided.

A functional behavioral assessment (FA) is required prior to creating a BSP and is intended to help identify whether there are other issues that could be contributing to the behavior. If another issue is identified and strategies to address the issue alleviate the behavior, then a BSP may not be necessary.

If the person's behavior is alleviated through a change in either the way staff interacts with him/her or changing environmental factors, a BSP may not needed. As an alternative to a BSP, the ISP team may consider developing Interaction Guidelines as a means of alleviating the behavior. These guidelines must focus solely on staff interactions and environmental factors.

If interventions are determined necessary, a BSP must be developed and the ISP team must document that each member of the team is aware of the plan.

General BSP requirements include:
~ documentation that the individual, the guardian or legal representative, and the ISP team are fully aware of the development of the plan;
~ a summary of the function of the behavior;
~ a clear, measurable description of the behavior which includes frequency, duration and intensity of the behavior; and
~ a clear description and justification of the need to alter the behavior.

All support documents, plans and protocols become part of the holistic ISP.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

As part of Waiver Case Management, service coordinators are responsible to provide information to and timely referral for individuals and their families regarding waiver and other Medicaid services, available providers, and services available from other agencies or organizations in the individual's community. The service coordinator must assist individuals and their families in accessing services, resources and available providers.

The individual's ISP must outline the services received and the type of provider selected to deliver the service. The ISP must be amended or updated to reflect any changes in provider type and/or services received.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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.
Service coordinators who approve the Individual Service Plan (ISP) are employees of CDDPs. The individual and/or their
legal guardian and the service coordinator review and approve the ISP. The coordinator writes the ISP based on the planning meeting and the individual and/or their legal guardian approves the written ISP. CDDP management looks at a representative sample of ISPs as part of QA and case review activities in order to assure that ISPs meet program standards.
Appendix D performance measures include both a DHS and OHA review of the ISP to ensure the ISPs are developed and implemented in accordance with the waiver.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The OARs for CDDPs describe the role of the service coordinator as the services and plan monitor. This includes monitoring the implementation of the ISP annually and any time there is a significant change; monitoring the ISP to make sure goals, objectives and actions agreed upon have been implemented; monitoring and reviewing on a regular basis, serious events, unusual incident reports, and individual finances as applicable to service setting.

(a) OARs cite the role of the CDDP and the service coordinator related to monitoring services and the plan. The service coordinator will monitor services for individuals receiving Medicaid services. For persons residing in a community-based service facility, this monitoring may be combined with visits as described in OAR. The service coordinator will determine if services are in accordance with the ISP and take appropriate actions to ensure services are delivered as specified in the plan.

(b) Service coordinator's service monitoring methods include visits to the service site, a review of the ISP, additional supports and protocols to assure that services are being provided as identified in the ISP; review of any serious events and unusual incidents; and a semi-annual review of the individual's financial plan; face-to-face meetings are made with the individual when possible.

If there are concerns regarding the services delivered, the service coordinator will notify the provider that changes in service delivery are needed and determine the need for technical assistance or other follow-up activities. This may include coordination or provision of technical assistance, consultation, corrective action; requesting assistance from DHS or other administrative support; meeting with the provider; or initiation of action to convene the ISP team and update the plan. The Services Coordinator and the CDDP are responsible for ensuring the appropriate follow-up to monitoring of services occurs.

The CDDP must notify the DHS when: a community-based service facility provider demonstrates substantial failure to comply with applicable licensing or certification rules; there is a serious and current threat endangering to the health, safety or welfare of individuals for which an immediate action by DHS is required; and when any individual receiving developmental disability services dies.

*Service Coordinators ensure prompt follow-up and remediation of identified problems during service plan implementation and monitoring by revising the ISP, discussions with family and providers and reconvening the ISP team to ensure that the ISP meets the individual's needs as identified and is driven by the individual or their representative. Problems are identified through contact with the individual or their representative, service providers or other individuals involved with the individual's ISP.

OAR 411-318 identifies individual rights, as well as the process to resolve complaints. This rule identifies that an individual has the right receive a timely response to any complaint or request for service/service change. In the event that an individual expresses dissatisfaction with a service, acknowledgement of this must be given, in writing, within 5 business days. If an informal review does not resolve the issue, a formal response must be given within 45 days. An expression of dissatisfactions may be given to a provider, an individual's Services Coordinator or Personal Agent, or to the Department.

(c) Frequency of ISP monitoring is based on the service delivery setting and applicable service OARs. At a minimum, the results of the ISP for individuals receiving services must be reviewed at least once within the plan year.

For individuals residing in a community-based service facility, site monitoring is conducted quarterly; service

monitoring and review is at least annually and addresses areas of review and questions established by DHS; monitoring of an individual's finances is semi-annually.

For individuals residing in their own or family home, service monitoring must occur annually, and if possible, in the individual's home. Otherwise a location may be negotiated with the individual. The ISP is the focus of these monitoring visits.

DHS also conducts its own reviews of the effectiveness of ISPs, accuracy of level of care, and consumer satisfaction related to services provided in an individual's own or family home via a consumer satisfaction survey.

The frequency of the aforementioned tools and methodologies follows:
~ Licensing or certification visits for community-based service facilities - every 1 or 2 years, as applicable for provider type.
~ DHS review of each CDDP - including a review of a statistically valid random sample of ISPs, client files, claims information, licensing information, are conducted at (a minimum of) 2 year intervals, or more frequently, as needed.

**Oregon requires annual face to face level of care assessment. Additionally, there is a minimum, quarterly reciprocal case management contact required with either the individual or the designated representative if the individual has 2 or fewer identified high risks as assessed using a risk assessment process which contributes to the ISP. Three or more identified high risks prompts monthly monitoring regarding issues of health and safety. When a change in need is identified by the individual, family, provider or during a monitoring visit, a new functional needs assessment is conducted which can result in a change to the ISP, including identification of new support needs and risk mitigation strategies. Additional monitoring is individualized, based on the needs of the individual and documented in progress notes and the ISP.

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:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: biennially	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Every 6 months

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:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

	☐ **Continuously and Ongoing**	Specify:
	☑ **Other** Specify: biennially	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: every 6 months

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:

Responsible Party for data		**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: biennially	

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

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

		OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: every 6 months

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: biennially	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data		**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: every 6 months

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:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: biennially	

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

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

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: every 6 months

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 revised to reflect individuals change in needs

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: biennially	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Every 6 months

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: biennially	

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

Responsible Party for data		**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Every 6 months

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

Performance Measures

For each performance measure 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:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: biennially	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Every 6 months

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: biennially	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Every 6 months

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 is reviewed and analyzed on a continuous and ongoing basis by the OHA liaison to DHS to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Upon completion of OHA' analysis and review of DHS' quality assurance data and reports, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the MOCSC. The Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) annually reviews the reports and document DHS and OHA remediation efforts. A Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) for OHA and DHS meet at least twice per year to review Medicaid/CHIP-related policy. The Steering Committee will be comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of policy-related issues and delineation of responsibilities, including establishment of a strategic plan for the two agencies. A Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) for OHA and DHS meet 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 MOCSC is comprised of the

administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and DHS. DHS staff address individual problems with 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 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. Non-compliance will be determined by any performance measure that falls below 86% accuracy.
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)
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*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

***(a) Nature of opportunities for participant direction.
DHS provides opportunities for participants and/or their legal representative to exercise Employer Authority in *Discovery/Career Exploration Services, Supported Employment - Individual Employment Support, Financial Management Services, Supported Employment - Small Group Employment Support, and/or Employment Path.*

Participants may find their own individual, non-agency Employment Path Services and Financial Management Services providers, screen otherwise qualified candidates for ability to meet participant needs, hire, supervise, direct and dismiss employees enrolled as qualified providers. Participants establish work schedules and train employees in how they prefer to receive their services.

A person-centered planning approach is required which assists the participant and their legal representative to establish outcomes, determine needs, plan for supports, and review and redesign support strategies. The planning process must address basic health and safety needs and supports, including informed decisions by the participant or the participant's legal representatives regarding any identified risks. A comprehensive needs assessment is completed for all participants.

(b) Process for accessing participant-directed services.
The Service Coordinator will discuss various waiver services options with every eligible individual/designated representative who chooses home and community-based services. When the individual's preference is to direct the waiver service, the SC will inform the individual/designated representative of the option to receive them from a domestic employee, independent contractor or provider organization.

(c) Entities involved in supporting participant direction and supports provided.
1) Information and assistance in support of participant direction:
~ CDDP Services Coordinators provide information to participants and their legal representatives regarding other agencies or organizations within the county that maintain lists of potential providers. All providers must meet minimum qualifications as defined by Oregon Administrative Rules including a criminal history check conducted by DHS. Participants select their own providers.
~ Supports to the employer include, but are not limited to: education about employer responsibilities; orientation to basic wage and hour issues; use of common employer-related tools such as job descriptions; and fiscal intermediary/employer agent services.
~ Most CDDPs have developed an orientation for participants that describes roles and responsibilities of participants, CDDPs and Providers.
~ The Services Coordinator monitors the service plan, identifying risks and unmet needs and discussing options with individuals. At a minimum, reassessments of the functional abilities and unmet needs are completed once a year. Services Coordinators are expected to identify and monitor more closely if the situation warrants, for example if the individual's health is particularly fragile, if there are provider issues, mental health concerns or protective service issues. The participant has the right to terminate the employment relationship with the provider at any time, for any reason.
~ Services Coordinators assist the individual in creating an individualized support plan based upon assessments of disability related needs, monitoring provider services, and monitor fiscal intermediary/employer agent functions on behalf of the individual.

2) Financial management services:
DHS contracts with outside Fiscal Intermediary (FI)/Employer Agent (EA) to perform the FI/EA duties. The CDDP is jointly responsible with the FI/EA for assuring financial management services are provided appropriately. Persons or agencies that act as FI/EA issue payment to the qualified provider and handle employer-related financial requirements on behalf of the participant-employer. The participant-employer signs off on time sheets and invoices verifying the number of hours their employee worked, up to the maximum hours authorized by the Individual Support Plan. Services Coordinators, by direct or telephone contact with the participant, may also verify services provided.

CDDPs may assist the participant with creating job descriptions and service agreements based on the Individual Support Plan.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

Specify these living arrangements:

Own or family home;
Adult Foster Home;
Group Care Home for Adults;
Supported Living.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

***All participants and/or their legal representative expressing interest in directing Discovery/Career Exploration Services,
Supported Employment - Individual Employment Support, Financial Management Services, Supported Employment - Small Group Employment Support, and/or Employment Path are informed of their service options when they apply for home and community based services. Participant/legal representative is assisted by their Services Coordinator to locate and arrange services, given information and technical assistance to make informed decisions about services and service providers, and assistance to monitor and improve the quality of services. Assistance may include referrals to qualified providers that the individual can choose to interview and hire.

OAR requires the provision of basic information by the CDDP to individuals prior to participants and/or their legal representative directing services. This information includes requirements for entry, conditions for exit; a description of processes involved in receiving services, including person-centered planning, evaluation, and how to raise and resolve concerns about services; and an explanation of individual rights to select and direct providers of services authorized through the individual's service plan from among qualified providers.

CDDPs are required to inform individuals, their legal representatives and families of their grievance and appeal rights. This information is provided both orally and in writing to participants by their Services Coordinator.

Individuals, prior to receiving participant-directed services, are informed of and must sign their acknowledgement that they may only use qualified providers. Individuals are informed of limitations of authorized services, if applicable, in the individual support plan.

Each CDDP provides or arranges for the individual and their family information on employer related supports:
~ Information on what it means to be an employer including employer responsibilities and risks associated with hiring and firing employees and potential risks related to employer insurance liabilities.
~ Websites for Bureau of Labor and Industries (BOLI) information.
~ Use of common employer-related tools such as job descriptions.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

○ **The State does not provide for the direction of waiver services by a representative.**

◉ **The State provides for the direction of waiver services by representatives.**

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

☑ **Waiver services may be directed by a legal representative of the participant.**

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

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

****Participant-approved friends or family members may supervise the completion of work provided by the provider. Relatives/legal representatives may not be paid to provide services. A friend who is a paid

provider may not sign off on his or her own timesheets or invoices showing the hours worked. All family members, neighbors, friends and other persons involved in the participant's life are assessed as voluntary natural supports before any paid supports are included in the Individual Support Plan. Payment can only be made for needs unmet by natural supports.
Based upon Oregon Administrative Rules, CDDPs may sanction any provider who has billed excessive or fraudulent charges or been convicted of fraud or has falsified required documentation. Sanctions imposed include the provider may no longer be paid with Medicaid funds, the provider may not be allowed to provide services for a specified length of time and/or until specified conditions for reinstatement are met and approved by the CDDP or Department, as applicable, and the CDDP may withhold payments to the provider.
CDDPs investigate any cases involving allegations of financial exploitation or refer the cases to the State of Oregon Medicaid Fraud Unit.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Employment Path Services	☑	☐
Discovery/Career Exploration Services	☑	☐
Supported Employment - Individual Employment Support	☑	☐
Financial Management Services	☑	☐
Supported Employment - Small Group Employment Support	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

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

The waiver service entitled:
Financial Management Services

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

Provide the following information

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

Fiscal intermediaries perform these services on behalf of the participant when participant direction is chosen: processing payroll, withholding Federal, state, and local tax and making tax payments to appropriate tax authorities, and issuing union dues to an employee union, if applicable.

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

Fiscal intermediaries are compensated for operating costs based on an agreed upon monthly amount.

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

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

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

Specify:

Supports furnished when the participant exercises budget authority:

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

Specify:

Additional functions/activities:

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

Specify:

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

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

CDDPs assist participants to choose services. When participants choose to receive services in their own or family home and they meet the requirements for receiving services in-home, CDDP Services Coordinators inform participants of the services and funding levels available under the waiver.
As stated in the previous section of this application, D-1-g, the state ensures that CDDPs are facilitating and monitoring services provided to individuals in their own or family home by:
~ Technical assistance provided to each CDDP by their assigned regional coordinator;
~ Administrative reviews and contested case hearings; and
~ Quality assurance activity:
~ Consumer satisfaction surveys.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Direct Nursing	☐
Family Training - Conferences and Workshops	☐
Waiver Case Management	☑
Employment Path Services	☐
Discovery/Career Exploration Services	☐
Supported Employment - Individual Employment Support	☐
Financial Management Services	☐
Environmental Safety Modifications	☐
Vehicle Modifications	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Supported Employment - Small Group Employment Support	☐
Specialized Medical Supplies	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants who voluntarily terminate their self-directed services are counseled by their service coordinator about other service options.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

An individual's or individual's representative may have their employer authority terminated when they are unable to meet the responsibilities of being an employer as evidenced by such things as:
(A) Independent provider complaints;
(B) Multiple complaints from an independent provider requiring intervention from the Department or CDDP;
Intervention includes such actions as:
(a) A documented review of the employer responsibilities described in OAR 411-330-0065;
(b) Training related to employer responsibilities;

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	375	
Year 2	400	
Year 3	425	
Year 4	450	
Year 5	475	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- [x] **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- [x] **Recruit staff**
- [x] **Refer staff to agency for hiring (co-employer)**
- [x] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [ ] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [x] **Other**

Specify:

Discharge any provider of service or vendor of supplies.

Appendix E: Participant Direction of Services

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

b. **Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☐ **Determine the amount paid for services within the State's established limits**
- ☐ **Substitute service providers**
- ☐ **Schedule the provision of services**
- ☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☐ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

DHS has implemented procedures to inform individuals of their right to request a Fair Hearing upon application, at the initial Level of Care (LOC), annually during the Individual Support Plan (ISP) meeting and upon request, by providing the FACT sheet (SDS 0948). The individual or their guardian signs the Notification of Rights document (form SDS 0949) documenting that they have been informed of their right to a file a complaint or request a hearing.

The Department has implemented rules that require anytime an individual's benefits/services are denied, terminated, suspended or reduced they will be given timely, written notice and advised of their fair hearing rights by receiving a Notification of Planned Action (form SDS 0947). The Notification of Planned Action includes the reason for the decision or action, the statute and rules relied upon in making the decision, the records used to make the decision, the manner in which to request a hearing and how to request continuing services as well as the individual's right to due process via a fair hearing. *Decision notices must be mailed at least 15 days prior to the action being taken, per Oregon Administrative Rule 461-175-0050.
*Individuals and/or their representatives are queried during the completion of a Fair Hearing request as to whether they want their benefits to remain the same during the proceedings. The individual records their preference on the hearing

referral form (SDS 0443) with the understanding that they may be liable for the costs of services received if the hearing decision is unfavorable to them.*

Upon receipt of a Notification of Planned Action or if the case management entity (Community Developmental Disability Program (CDDP), Children's In-Home Services (CIIS) or Support Services Brokerage) failed to make a timely decision, the individual or their representative may request a Fair Hearing. The request for a Fair Hearing is made by completing the Administrative Hearing Request form (SDS 0443DD) and submitting the form to the case management entity or DHS, or making an oral request for a hearing to either the case management entity or the Department. If a request for a hearing is made orally by the individual or their representative, the case management entity which receives the request for hearing must complete the Administrative Hearing Request form (SDS 0443DD) and submit the form to the Department.

DHS employs lay hearing representatives who represent the Department in all Fair Hearings. Upon receipt of the hearing request, the Department refers the hearing request to a DHS lay representative who is responsible for referring the hearing request to the Office of Administrative Hearings (OAH). *Hearings Representatives are employees of the Department. The "lay" denotation refers to the fact that the representatives are not attorneys, nor are they permitted to make legal arguments during the administrative proceedings. The State Attorney General delegates the authority for such representation in these specific administrative contested-case hearings.*

Upon receipt of an Administrative Hearing Request form (SDS 0443DD), the Department reviews the hearing request and obtains a copy of the records that were used in the decision to deny, reduce, suspend or terminate the benefit or service. The Department acts as the liaison between the case management entity, the DHS lay representatives and OAH. The Department is responsible for referring the hearing request to the DHS lay representative, who reviews both the Notification of Planned Action (SDS 0947) that was sent to the individual and the request for the hearing (SDS 0443DD). The DHS lay representatives are centralized and not part of any local office that determines benefits, services, or eligibility. Hearings are held by the Office of Administrative Hearings, which is independent from the Department of Human Services.

The DHS lay representative facilitates an informal phone conference between the individual or their representative and the Department. The informal conference is an opportunity to provide the individual or their representative the opportunity to question the planned action and to present additional information if applicable.

For all hearings that are held before an Administrative Law Judge, the individual or their representative is sent a Notice of Hearing by the OAH with a date and time for a hearing. All hearings are held over the phone unless the individual or their representative requests to have the hearing in person. The outcome of the hearing results in a Proposed Order, Proposed or Final Order, or Final Order that is issued by the OAH. If a Proposed Order is issued, the Department issues a Final Order after 21 days if no written exceptions are filed.

If the individual or their representative disagrees with the Final Order the individual or their representative may appeal the final order by filing a petition in the Oregon Court of Appeals.

The Department maintains a database and tracks each phase of the hearings and the outcome(s) for each hearing. Additionally, the Department maintains a file of all records relied upon during the hearing. A copy of the hearing request and Final Order is sent to the case management entity upon completion of the hearing.

All applicants and recipients of Department programs that require written materials in alternative formats or in their native language are accommodated as well as individuals that require translation or interpreter services. The assistance relies on professional translators/interpreters or services such as Language Lines, ASL, TTY. Other forms of augmentative and/or alternative communication are also options for these individuals.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

Department of Human Services

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Oregon Administrative Rule governs Oregon's complaint process.
Complaints may be filed with several entities including:
(A) Complaints regarding dissatisfaction with the services of a provider organization may be filed directly with the provider organization, with the individual's CDDP, or with the Department.
(B) Complaints regarding dissatisfaction with the services of a CDDP may be filed directly with the CDDP, or with the Department.
(C) Complaints regarding dissatisfaction with the Department must be filed with the Department.

A complaint is an expression of dissatisfaction with services or service providers. The CDDP is required to inform individuals or the individual's representatives of their right to file a complaint upon start of services, annually and upon request by providing a Fact Sheet about Complaints. The fact sheet explains the process of how to file a complaint and response expectations by the CDDP and DHS.
The CDDP is required to address all complaints made by individuals or the individual's representative in accordance with their policies and procedures and the OAR Chapter 411, Division 318. CDDPs must have and implement written policies and procedures regarding individual complaints and the complaint process. They are required to keep and maintain a Complaint Log as defined in the above referenced OAR.
DHS and local case management entities (CDDP) must screen all complaints they receive for potential hearings related issues and issue a Fair Hearing Notice when appropriate. Complaints regarding dissatisfaction with services or service providers can be made verbally, in writing or on the DHS Complaint form (SDS 0946) and be submitted to the CDDP directly or to DHS.
There are defined timelines the CDDP has for responding to complaints, which are:
~ The CDDP must acknowledge receipt of the complaint within 5 working days.
~The CDDP must offer the individual the opportunity to participate in an information discussion about the complaint. This informal discussion must occur within 10 working days of the acknowledgement.
~ If a resolution is reached during the informal conference discussion, the CDDP must provide a written description of the resolution to the individual or the individual's representative within 10 working days of the informal discussion.
~ If a resolution was not reached during the informal conference discussion, the CDDP must complete a review of the complaint and issue a written outcome within 30 calendar days of the receipt of the complaint, unless both

parties mutually agree to another 30 calendar day extension.
The written outcome must include; the rationale for the outcome, cite documents or other information relied on in deciding the outcome, information about the individual or the individual's representative's right to review the relied upon documentation and the process for appealing to DHS, the CDDP's written outcome.
The individual or the individual's representative has the right to appeal to DHS, the CDDP's written outcome within 30 calendar days of receiving the written outcome. DHS also has the same time frames associated as listed above in responding to complaints and appeals and providing the individual or the individual's representative the right to review the documents relied upon in resolving the complaint or appeal. DHS has a complaint tracking database which has the capability to consistently track all complaints that are not resolved at the CDDP level. The complaint database is utilized to track whether the complaint process is timely, identify any potential trends across the services system geographically or statewide, as well as contributing to Quality Assurance/Quality Improvement activities.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DHS requires the reporting of certain critical incidents for adults and children with developmental disabilities as addressed in OAR. This reporting is done across all service settings as events occur. Reporting may occur by phone, in-person, email, writing, or verbally.
DHS maintains a secure, web-based system, Serious Event Review Team (SERT), for identification and tracking of abuse allegations and certain serious events. Service Coordinators enter critical or unusual incidents, described below and defined by OAR, into SERT. Utilization of the SERT system is mandatory.

Serious events and time frames in which they must be reported are as follows:
Any allegation of abuse - as defined by Oregon statute or administrative rule - of an individual with developmental disabilities is considered a serious event. Service providers must immediately report allegations of potential abuse to the CDDP, Law Enforcement or Child Welfare based upon the nature of the allegation and investigative authority.
Service providers are required to submit incident reports to guardians/legal representatives, upon their request, within 5 days from the date the request is made.
CDDPs enter information about the event into the SERT database within one working day of receipt of the report.
Instances of abuse are defined in Oregon Revised Statutes and OARs as:

~ Death (caused by other than accidental or natural means, or occuring in unusual circumstances);
~ Abandonment;
~ Financial Exploitation;
~ Involuntary Seclusion/Restraint;
~ Neglect;
~ Physical Abuse;
~ Sexual Abuse; and

~ Verbal Abuse;

CDDP Abuse Investigators are responsible for determining whether or not an allegation of abuse meets the threshhold for an Abuse Investigation (AI). The decision is based on the type of allegation reported as well as a cursory evaluation of circumstances using instruction and advice from Office of Adult Abuse Prevention and Investigations (OAAPI). Upon entry of any allegation of abuse into SERT, a decision to proceed with an abuse investigation is required. If necessary, due to findings of subsequent review or investigation, the CDDP can update the SERT database to change this decision.

CDDPs often receive reports that must also be referred to other agencies for investigation or other resolution:
- DHS, Child Welfare investigates child abuse or may delegate investigation responsibility to OAAPI.
- If a crime occurs, law enforcement is involved.
- OAAPI investigates allegations of abuse involving individuals residing in State Operated Community Programs (SOCP). Because of the involvement of different investigative agencies in certain cases, investigation information, processes and timelines are not under a CDDP's immediate control.

The SERT system generates a referral to OAAPI that an abuse investigation is required, as well as documents referral to other appropriate investigative agencies. SERT also contains information regarding what the CDDP knows or learns about the case (including reports and outcomes shared by the investigating agency), and CDDP activities (e.g. action to protect individual, collaboration with investigating agency, monitoring investigation progress, subsequent or separate investigation, follow-up on recommendations or required actions) prior to closure. AIs are required to be completed within 45 days of the date the event was originally entered into the SERT database unless an extension is approved by OAAPI. Participation of other investigative agencies, e.g. State and/or Law Enforcement, may cause a delay in completion of those investigation.

Service providers are required to report non-abuse related serious events to CDDP Services Coordinators within 5 working days. Non-abuse related serious events must be monitored and must be entered into SERT no more than five calendar days after CDDP receives notification of the incident.
Serious events include:

~ Death (accidental or natural causes);
~ Medical hospitalization; and
~ Psychiatric hospitalization.

CDDP Services Coordinators or CDDP management, separately or as a team, clarify the nature of these serious events and take any steps necessary to address causes and prevent recurrence. It is not necessary to complete the entire County Review of Serious Event form on initial entry; CDDPs update the record as the review process develops and concludes. The form must be completed -as indicated by the date entered in the Date Review Completed field- within 45 days of entering the serious event in SERT.
The SERT Manual provides instructions for identifying what incidents constitute a County Review, entering data about the County Review process, and updating the County Review record.

Each indiviual participant and/or their family or their legal representatiave, as appropriate, recieves information of their rights as a client, including their right to safe services, and how and where to report suspected abuse or neglect. This information is provided by CDDP Services Coordinators who also encourage participants, through phone and direct contact, to communicate concerns, complaints or reports of abuse at any time. Particpants are also informed of their rights, including their right to safe services and to make complaints and report abuse, neglect or exploitation, at the time they begin receiving services and during the annual ISP process. This information comes from the CDDP Services Coordinator or from service providers or both. Individuals residing in 24-Hour residential settings are supplied with wallet cards that include information on abuse, neglect and exploitation, and the local abuse reporting phone numbers. Individuals, their families, or legal representatives are also informed that their CDDP Services Coordinators and their service providers are mandatory reporters of suspected abuse and neglect.

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.

Oregon DHS maintains extensive Web and printed materials on how to report abuse and neglect of children and adults.

DHS, Office of Adult Abuse Prevention and Investigation (OAAPI) provides the following trainings to individuals and providers at the frequency described below and when requested:

1) Making Sense of the Abuse Reporting System: a three hour training for family members and consumers/customers, which providers also find of value. This training covers the abuse reporting statute and the OARs in depth, in common sense language designed for the target audience. It includes information on what to report, how to report, who to report to, and also includes OAAPI's toll free abuse reporting number for emergency after hours access. This training is offered six to 10 times per year.

2) Could This Happen in Your Program?: Designed for providers of services to individuals with mental illness and/or developmental disabilities and uses case studies to surface the very real issue of appropriate 911 and emergency services referral and contact situations. The workshop also covers reportable abuse incidents which fit statute and OAR definition and goes further to discuss protocols and policies organizations might have in place-or need to develop- both situations that may not rise to the threshold of reportable abuse. This training is conducted 2 to 3 times per year.

3) The Choices We Make: This is a new video and desktop training package which contains two DVDs and a participant workbook. The target audience is community providers and partners, though family members and self advocates have found it helpful. The DVDs cover all of the abuse reporting statute and OAR information and offer 8 individual vignettes, filmed across the state using real providers and consumers as the actors, illustrating different possible incidents which may or may not rise to the reportable threshold. The workbook is designed to be self paced and is a supplement to the film, allowing for managers and/or individuals to test their understanding of the material covered in the film. More than 2000 copies of this training material have been sent out. Copies were mailed to every DHS and Addictions and Mental Health Division (AMHD) licensed adult foster home, every provider organization's central office, and every Community Mental Health Program and CDDP. These entities show the materials as they deem fit but OAAPI has received very positive feedback that entities both like it and use it regularly. The materials are also used to supplement some mandatory abuse trainings for providers approximately 10 to 20 times per year.

4) Provide technical assistance and presentations on abuse prevention and reporting by request, and as schedule permits, to community partners, self advocacy groups, survivor groups, and providers.

In all of these trainings and presentations, the OAAPI toll free abuse reporting number is presented and the connections made between the participants and the appropriate local county reporting entity the individual would usually use as their first contact.

Protective services are those steps taken to prevent abuse or neglect and to keep people safe. Protective services are provided for all adults and children with developmental disabilities who are eligible for or are receiving DD services in the community. Individuals who are able to make their own decisions may refuse to accept offered services.

Protective services can include:
~ Assisting in or arranging appropriate services and alternative living arrangements;
~ Assisting in or arranging the medical, legal or other necessary services to prevent further abuse;
~ Providing advocacy to assure the individual's rights and entitlements are protected;
~ Arranging for the immediate protection of the individual;
~ Contacting the adult to assess his or her ability to protect his or her own interest and give informed consent;
~ Determining the ability of the adult to understand the nature of the protective service and his or her willingness to accept services; and
~ Coordinating evaluations to determine or verify the individual's physical and mental status, if necessary;
~ Coordinating with the protective service investigation enties (law enforcement, DHS Child Welfare, DHS Office of Investigation and Training) to assure a full complete investigaton, and appropirate correction and follow-up plan.

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.

Service providers must submit incident reports on non-abuse related serious events to CDDP Service Coordinators within five working days. They must also submit incident reports to guardians/legal representatives, upon their

request, within five days from the date the request is made.
Service providers must make immediate notification of allegations of potential abuse to the CDDP, Law Enforcement or Child Welfare.
CDDPs are required to enter statutorily defined instances of abuse into the SERT database within 1 calendar day of notification. For other serious events that may not constitute abuse, CDDPs are required to enter the incident into SERT within 5 calendar days upon notification. CDDPs are required to complete their County Review process and Abuse Investigations within 45 from date of entry of incident into SERT database (barring any delays by law enforcement or other investigative agency).
CDDP SERT teams convene at least quarterly to develop local and system-wide responses and preventive actions to address system deficiencies or emerging concerns that could potentially harm individuals served.
Abuse related investigations are generally conducted by CDDP abuse investigators. However, OAAPI may conduct abuse investigations in the event of a conflict of interest at the CDDP, when asked for assistance by the CDDP, or when the alleged abuse or serious event occurs in a State Operated Community Program (SOCP).
Child Welfare and/or a law enforcement agency (LEA) conduct investigations for all children residing in certified foster homes or within the family setting. The local CDDP and OAAPI may be contacted to provide consultation in child foster home investigations involving a child with DD. The CDDP and/or ODDS may be directly involved in implementing specific protective service recommendations in child foster homes. CDDP Abuse Investigators conduct investigations for children residing in 24-hour residential settings (Group Care Homes).
Law Enforcement Agencies (LEA) or local District Attorneys (DA) are responsible for investigating criminal allegations. These entities do not have access to the SERT database. CDDP SERT entries note referrals for investigation in cases involving individuals with DD where there is reason to suspect a crime has occurred. Local LEA and DA may collaborate with the local CDDP or OAAPI in response to/investigation of serious events where there is reason to suspect a crime has occurred and may inform the CDDP about the outcome of the criminal investigations. However, they are not required to release any information on the outcomes of investigations to DHS.
Per OAR, upon completion of the abuse investigation, and within 45 calendar days of the date of a report alleging abuse, the CDDPs will prepare an abuse investigation and protective services report which includes:
(a) A statement of the alleged incident being investigated, including the date(s), location(s) and time(s);
(b) An outline of steps taken in the investigation, a list of all witnesses interviewed and a summary of the information provided by each witness;
(c) A summary of findings and conclusion concerning the allegation of abuse;
(d) A specific finding of substantiated, inconclusive or not substantiated;
(e) A list of protective services provided to the adult to the date of the abuse investigation and protective services report;
(f) A plan of action necessary to prevent further abuse of the adult;
(g) Any additional corrective action required by the community program and deadlines for the completion of these action;
(h) A list of any notices made to licensing or certifying agencies;
(i) The name and title of the person completing the report; and
(j) The date it is written.
Abuse investigation and protective services report formats will be provided by DHS.
A copy of the abuse investigation and protective services report will be provided to DHS within five working days of the report's completion. Portions of the abuse investigation and protective services report and underlying investigatory documents are confidential and not available for public inspection. The Department will make the confidential information, including any photographs, available, if appropriate, to any law enforcement agency, to any public agency that licenses or certifies facilities or licenses or certifies the persons practicing therein, and to any public agency providing protective services for adults. The Department will also make the protective services report and underlying investigatory materials available to any private agency providing protective services for the adult and to the protection and advocacy system designated pursuant to ORS Section 192.517(1).
A redacted version of the abuse investigation report, not containing any confidential information, will be available for public inspection.
When the abuse investigation is conducted and protective services report is completed by a CDDP, as the Department's designee, the abuse investigation may be disclosed pursuant to OAR either by the community program or the Department.
The community program must provide notice of the outcome of the investigation or assure that notice is provided to the alleged victim, guardian, provider agency and brokerage, accused person and to any law enforcement agency which previously received notice of the initial report. Notice of outcome shall be provided to a reporter upon the reporter's request. Notice of outcome must be made within five working days after the date the case is completed and approved by OAAPI. The community program must document how the notice was provided.

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.

Oregon Department of Human Services, Office of Developmental Disabilities Services (ODDS) is responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants.
Local CDDP and State staff review critical incidents and related follow-up data on a regular basis to identify emerging trends.
Local CDDP SERT teams convene at least quarterly to develop local and system-wide responses and preventive actions to address system deficiencies or emerging concerns that could potentially harm individuals served.
DHS staff compile, review and analyze performance data through CDDP reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to CDDPs as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. ODDS staff follow-up with CDDPs to ensure appropriate action is taken.
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 and 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.

Appendix G: Participant Safeguards

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

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

◉ **The State does not permit or prohibits the use of restraints**

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

The individuals enrolled in the Comp Waiver Plans of Care do not include the use of restraints or seclusion. Support Coordinators who oversee the Plans of Care and the services delivered report any use of restraints or seclusion to the CDDP, who in turn enters the information into the SERT system. If harm is caused or there is a threat of harm, a report of abuse may be made to local law enforcement. Support Coordinators, through regular contact by phone, e-mail and visit with the individual, families and providers, perform continual service monitoring and guidance to individuals and families about the individual's care and safety needs and appropriate service provision.

○ **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:

The individuals enrolled in the Comp Waiver Plans of Care do not include the use of restraints or seclusion. Support Coordinators who oversee the Plans of Care and the services delivered report any use of restraints or seclusion to the CDDP, who in turn enters the information into the SERT system. If harm is caused or there is a threat of harm, a report of abuse may be made to local law enforcement. Support Coordinators, through regular contact by phone, e-mail and visit with the individual, families and providers, perform continual service monitoring and guidance to individuals and families about the individual's care and safety needs and appropriate service provision.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

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

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

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

The individuals enrolled in the Comp Waiver Plans of Care do not include the use of restraints or seclusion. Support Coordinators who oversee the Plans of Care and the services delivered report any use of restraints or seclusion to the CDDP, who in turn enters the information into the SERT system. If harm is caused or there is a threat of harm, a report of abuse may be made to local law enforcement. Support Coordinators, through regular contact by phone, e-mail and visit with the individual, families and providers, perform continual service monitoring and guidance to individuals and families about the individual's care and safety needs and appropriate service provision.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

All residential providers of services are required by Oregon Administrative Rules to have written policies and procedures that maintain and protect the physical health of an individual receiving service. Policies and procedures must address: individual health care; medication administration; medication storage; response to emergency medical situations; nursing service provision if provided; disposal of medications and early detection and prevention of infectious disease. Provider organization staff are required to demonstrate competencies in administering and charting medications. Agency supervisory staff are required to validate the competency of new staff before they dispense medications to individuals.

For individuals receiving services from 24-hour Residential, Adult Foster Care, Children's Developmental Disability Foster Care, and Employment providers, the provider is responsible for the ongoing monitoring of participant medication regimens, unless the individual has a variance to self medicate. For individuals receiving services from Supported Living providers, the responsible party could either be the individual or provider, depending on the individual's support need, and should be outlined in the ISP. For individuals receiving services in their own or family home, the individual, the family, or agency/provider could be the responsible party, again, depending on support need and outlined on the service plan/job description.

CDDP Services Coordinators are charged with providing regular monitoring of residential provider sites licensed or certified by the Department, which are serving people with developmental disabilities. Specific questions are required to be asked with regard to each person living in the home and in the following areas of service: financial, medical, behavioral and the Individual Support Plan (ISP). Each residential site will have a visit by a Services Coordinator at least quarterly.

Questions and considerations to cover when gathering the information regarding medication review include the following:

Did you review the Medication Administration Record?

~ Check to make sure that the person's name is on the MAR.
~ The following should be included on the MAR: transcription of the written physician's or licensed health practitioner's order; brand or generic name of medication; prescribed dosage; frequency; and administration method.
~ Known allergies or adverse drug reactions are noted on the MAR.
~ Does the MAR match the Physician visit record/Doctors orders/Rx labels?

Does the MAR indicate medications were given as directed?
~ Times and dates of administration or self-administration are noted.
~ A signature is present of the person administering the medication (or the persons' signature if (s)he is self administering).
~ Explanation noted if a PRN (as needed) is administered.
~ Documentation exists, describing the effectiveness of the PRN.
~ Medication administration irregularities are noted.
~ Written explanation provided for medication irregularities.
~ Staff signatures are present to acknowledge medication irregularities.
~ Evidence that appropriate follow up activity occurred following a med error (e.g. late missed medication protocol implemented).
~ Medications are present, locked and secured.
~ Bubble packs appear to be used according to schedule; pills appear to have been given (no remaining pills for dates past).

Are psychotropic medications being used?
~ Psychotropic medications may include, but are not limited to anti-psychotic, antidepressant, anxiolytic (anti-anxiety) and behavior medications.
~ Psychotropic medication is prescribed with the intent to affect or alter thought processes, mood or behavior. Sometimes psychotropic medication is prescribed for other health reasons. When psychotropic medication is prescribed to alter thought process, mood or behavior, the protections described in the OAR must be met.

If yes, are the psychotropic medications being used in compliance with the appropriate OARs?
~ Physician's written order is present.
~ Evidence that the prescribing physician, ISP team and program are monitoring the behaviors of the person. Medication is promoting desired responses and decreasing adverse consequences.
~ When psychotropic medication is prescribed to alter thought process, mood or behavior, the protections described in the OAR must be met:
~ According to the OAR governing Adult Foster Home providers, the balancing test documents the health care provider's decision that the benefits of the medication outweigh the potentially harmful effects of the medication. It is obtained annually from the prescribing physician or nurse practitioner.
~ According to the OAR governing 24 Hour Residential providers of services for Children and Adults with Developmental Disabilities OARs, a DHS approved Balancing Test form is present, following the first prescription of the psychotropic medication. There is evidence of a balance test being completed annually, if medication is continued.
~ PRN/Psychotropic medication is prohibited. Only in very rare circumstances have variances been permitted. If psychotropic medication is administered, a variance is in place and followed.
~ OAR requires that the provider keep signed copies of the DHS Balancing Test form in the individual's medical record for seven years. If relevant, is the documentation present?

The CDDP maintains documentation in the individual's case file of medication administration errors. Errors that lead to an allegation of abuse are reported in SERT. The CDDP's review of the IRs may lead to an abuse investigation (AI) being conducted by the CDDP's Abuse Investigator.
Information regarding these investigations is sent to the DD Licensing Unit of the Office of Licensing and Quality of Care (Licensing Unit) for review and follow-up (if follow-up is deemed necessary). AI reports may be used by the Licensing Unit to determine non-compliance with Oregon Administrative Rules on the part of the provider and the potential need for further licensing actions, such as additional licensing visits or sanctions.

Providers are responsible for working with the individual's ISP team to determine the individual's abilities and deciding if self-administration should be considered for the individual.

The Licensing Unit reviews the team's decision, the current ISP, and the documentation in the MAR. Documentation may be made by staff or documentation by the self-administering individual. Any medication irregularities or errors are reviewed to determine what actions were taken by the provider/staff and follow-up is conducted with the ISP team if an error is significant enough to warrant a re-visit of the issue.

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.

DHS, Office of Licensing and Regulatory Oversight conducts complaint investigations that are the result of a request from the CDDP or as a result of an IR or AI.
A mid-cycle monitoring review may be conducted nine to fifteen months after renewal of the providers licensing for the following:
~ Failure by the provider to successfully complete licensing renewal as evident by two or more follow up reviews;
~ Failure by the provider to successfully complete plans of correction for abuse investigations; and
~ Upon request of the CDDP or other Department designee, or the provider.
Monitoring reviews can be a review of supports and services provided one or more individuals, a specific review of an issue for one or more individuals served, a review of the providers system addressing past problems, or a review around the licensing process.

Licensing visits and reviews 24-hour Residential sites and Supported Living sites every two years. Prior to licensing visits, the licensing team reviews any data stored in the SERT system regarding the residence or individuals residing in the residence.

During the licensing visit the licensing team:
~ Reviews physician's orders, medication administration records, and IRs for individuals sampled to determine if there have been any irregularities and review the actions taken by the provider to correct the issue;
~ Reviews personnel records for documentation of training on medication administration (Core Competency) or actions taken related to medication errors;
~ Looks at medication labels to see if prescription medications are from a single pharmacy and if the label matches the order;
~ Looks at drug disposal records for medications not used and looks at the individual's record to determine why the drugs were disposed of;
~ Looks at providers system for handling, use and accountability of controlled substances. Reviews records for individuals who have had controlled substances prescribed.
~ Looks for drug reference source(s).

Potentially harmful practice identified during a licensing visit will be communicated to the provider immediately so that action can take place right away.

A plan of correction is required to be submitted to the Licensing Unit and a copy to the CDDP. The plan must identify what actions have been taken to prevent the reoccurrence of the problem. Supporting documentation may be required to be submitted to the Licensing Unit. The plan of correction is reviewed by the Licensing Unit to assure it addresses the issue. Oral follow-up occurs if it does not.

Further licensing action may result based on the nature of the error, such as another visit by the Licensing Unit.

Any statutorily defined incident of abuse must be reported in the SERT system within 1 day of the CDDP's receipt of the incident report (IR). The ODDS staff review state and local processes for web-based reporting, local SERT meeting minutes, and SERT data during regularly scheduled meetings. It is the state's duty to assess CDDP's SERT data to identify trends relating to deaths, incidents of alleged abuse, and other serious or unusual incidents.

DHS provides requested training to CDDPs for accurate SERT reporting and utilization of SERT data for

developing Quality Improvement activities.
DHS staff compile, review and analyze performance data through CDDP reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to CDDPs 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 with CDDPs to ensure appropriate action is taken.

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)*

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).

DHS governs the administration of medications to waiver participants by waiver providers in various Oregon Administrative Rules.

Medication administration may be conducted by licensed medical personnel and non-medical waiver provider personnel. Often, Registered Nurses (RN) delegate medication administration when appropriate, the RN trains the identified personnel, and monitors the delegation. For others, the service provider organization is required to provide adequate training and monitoring of its staff that administer medications. Some tasks may not be delegated by an RN to non-medical provider personnel, i.e. medication administration methods that require RN (IV injections, etc).

Per OAR, the provider must have and implement a competency-based staff training plan, which meets, at a minimum, the competencies and time lines set forth in the Department's Oregon Core Competencies. One of the competencies listed is "Demonstrate appropriate medication administration and documentation."
The training form includes what needs to be demonstrated:
~ Verify physician's orders;
~ follow organizations approved medication administration procedures;
~ Administer meds according to individuals physician order sheet;
~ Complete required documentation.

Per OAR, staff must have met the basic qualifications in the provider organization's competency based plan (which must include the above-listed requirements).

The Office of Licensing and Regulatory Oversight looks for documentation in staff records confirming that staff have completed the providers Core Competencies as outlined.

A provider organization may have a registered nurse working for them who has reviewed their medication administration training program and provide input.

The provider must have and implement policies and procedures that maintain and protect the physical health of individuals. Policies and procedures must address the following:
~ Individual health care;
~ Medication administration;
~ Medication storage;

~ Response to emergency medical situations;
~ Nursing service provision, if provided;
~ Disposal of medications; and
~ Early detection and prevention of infectious disease.

All medications and treatments must be recorded on an individualized medication administration record (MAR).
The MAR must include:
~ The name of the individual;
~ A transcription of the written physician's or licensed health practitioner's order, including the brand or generic name of the medication, prescribed dosage, frequency and method of administration;
~ For over the counter topical medications without a physician's order, a transcription of the printed instructions from the package;
~ Times and dates of administration or self administration of the medication;
~ Signature of the person administering the medication or the person monitoring the self-administration of the medication;
~ Method of administration;
~ An explanation of why a PRN (i.e., as needed) medication was administered;
~ Documented effectiveness of any PRN (i.e., as needed) medication administration;
~ An explanation of any medication administration irregularity; and
~ Documentation of any known allergy or adverse drug reaction.

For individuals who independently self-administer medications, there must be a plan as determined by the ISP team for the periodic monitoring and review of the self-administration of medications.
Providers must ensure that individuals able to self-administer medications keep them in a place unavailable to other individuals residing in the same residence and store them as recommended by the product manufacturer.

Psychotropic medications and medications for behavior must be:
(A) Prescribed by a physician or health care provider through a written order;
(B) Monitored by the prescribing physician, ISP team and program for desired responses and adverse consequences. PRN (as needed) psychotropic medication orders will not be allowed.

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:

While providers record all the following medication errors, only some rise to the level of being reported to the CDDP. The Office of Licensing and Regulatory Oversight reviews a sample of the medication error reports and looks to correlated information on the medication administration record and physician's order to identify if there were errors that were not reported. Action is based on the severity of the error.

Medication error reports are required for medication:
~ Given at the wrong dosage;
~ Given at the wrong time (if there is no physician order in place directing what actions to take);
~ Given by the wrong route;
~ Not given, missed or refused (if there is no physician order in place directing what actions to take); and
~ Given to the wrong person.

Any medication error that results in the individual being taken to the emergency room or hospital requires immediate notification of the CDDP.

Any missing controlled medications must be reported to the CDDP.

The CDDP maintains documentation in the individual's file, available to State staff, of medication administration errors that lead to an allegation of abuse.
Also submitted to the CDDP via an IR are reports of errors that could lead to potential harm, i.e. missed medications or medications administered to the wrong person.

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.

Medication administration and management is monitored during licensing and certification visits to provider sites conducted by DHS', Office of Licensing and Regulatory Oversight . The Office of Licensing and Regulatory Oversight reviews past medication administration records, prescribing practitioner orders, and any documentation of medication administration irregularities during licensing onsite visits. Any medication error report reviewed by Licensing includes determining if the provider identified the cause of the irregularity, what actions were to be taken to correct any problem identified and reviewing documentation to assure action had been taken as indicated on an Incident Report (IR). The Office of Licensing and Regulatory Oversight reports negative findings of an individual site. Any negative findings will require a plan of improvement. Statewide licensing findings regarding citations for medication administration can be tracked using the Licensing Unit's computer system.
CDDP Services Coordinators review individuals' Medication Administration Records (MARS) during monitoring visits for indications of medication administration errors.
Providers must document on an IR any medication administration irregularities or errors, perform an administrative review of the event to determine the cause, plan to prevent a reoccurrence, and document the organization's administrative response to such errors. IRs regarding errors that could lead to potential harm (missed medications or medications administered to the wrong person) are sent to the CDDP. Any errors resulting in harm to an individual will be investigated for potential neglect.
The CDDP enters information into the SERT system of medication administration errors that lead to an allegation of abuse. The CDDP's review of the IR may lead to an Abuse Investigation (AI) being conducted by the CDDP's Abuse Investigator.
Information regarding these investigations is sent to DHS' Office of Licensing and Regulatory Oversight for review and follow-up (if follow-up is deemed necessary). AI reports may be used by the Licensing Unit to determine non-compliance with Oregon Administrative Rules on the part of the provider and the potential need for further licensing actions, such as additional licensing visits or sanctions.
In addition to the Office of Licensing and Regulatory Oversight 's reviews of providers, DHS conducts site visits to CDDPs on a regularly scheduled basis. Approximately seven CDDP's are reviewed every year. Each CDDP is reviewed every 5 years on this schedule and more often if problems arise or the need for a review is identified in the interim. During site visits ODDS staff review all aspects of the DD program including, but not limited to, incident reports, a statistically valid number of client case files, CDDP complaint logs, complaint outcomes, and remediation documentation.
DHS staff compile, review and analyze performance data through CDDP reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to CDDPs 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 with CDDPs to ensure appropriate action is taken.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
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:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: biennially	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

Data Source (Select one):
Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: every 6 months

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 deaths occurs

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 initial incident reports

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: biennially	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: every 6 months

Performance Measure:
PM29: Number and percent of investigations that were conducted appropriately according to Oregon Administrative Rule 407-045-0300 N: Number of CDDP investigations that were conducted in accordance with Oregon Administrative Rule 407-045-0300 D: Total number of CDDP investigations conducted

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

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

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: every 6 months

Performance Measure:
PM30: Number and percent of investigations conducted by in accordance with Oregon Administrative Rule 413-015 N: Number of Child Protective Services (CPS) investigations conducted in accordance with Oregon Administrative Rule 413-015 D: Total number of CPS investigations conducted

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: biennially

Performance Measure:
PM31: Number and percent of investigations conducted by CDDP in accordance with Oregon Administrative Rule 407-045-0320 N: Number of investigations conducted by CDDP in accordance Oregon Administrative Rule 407-045-0320 D: Total number of investigations conducted by CDDP

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: every 6 months

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:
PM32: Number and percent of allegations regarding wrongful restraint and involuntary seclusion where investigations are conducted in accordance with OAR 407-045-0320 N: Number of allegations regarding wrongful restraint and involuntary seclusion where appropriate actions and follow-up occurred D: Total number of allegations of wrongful restraint and involuntary seclusion

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	

		☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: every 6 months

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:
PM33: Number and percent of waiver participants with a serious risk(s) identified on the Risk Identification Tool (RIT) where there is evidence of follow-up. N: Number of waiver participants with a serious risk(s) identified on the RIT where there is evidence of follow-up. D: Total number of wavier participants reviewed with a serious risk(s) identified on the RIT.

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

Responsible Party for data		**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Biennially	

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

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

		OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
**Individual remediation activities will require follow-up by the OHA and/or DHS Quality Management staff
to determine that the corrective action was successfully completed by the field office, licensing or abuse investigation unit. The results of any remediation will be submitted to an inter-departmental workgroup for discussion, data collection and reporting. When individual and/or system-wide remediation activities are warranted based on discovery and analysis, the following time frames will be used to ensure these items are remediated in a timely manner. Non-compliance will be determined by any performance measure that falls below 86% accuracy.
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)
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*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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)

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 (CDDPs and Brokerages), 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/CHIPrelated
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*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

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-ODDS Central Office (CO), ODDS, CDDPs, and Brokerages administers all services delivered through the waiver operated by DHS- ODDS.
ODDS, CDDPs, Brokerages and CO staff uses findings from discovery and remediation activities related to the six assurances and other parameters to establish priorities for system improvement and evaluate the effectiveness of those improvements.
ODDS, CDDPs, Brokerages and CO staff seeks input from participants, families, providers, and other interested parties/groups to find ways to deliver waiver services more effectively and efficiently and move the
participant toward outcomes stated in approved plans of care.
ODDS, CDDPs, Brokerages and CO staff collects QI information from the performance measures related to the six assurances and other topic areas. They work with participants, families, providers, and others to address
both concerns raised and improvement opportunities identified. DHS staff compiles reviews and analyzes performance data through a variety of file reviews and data reports. Corrective action/remediation plans arerequired 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, 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, 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.
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, ODDS Central Office staff follow-up to ensure appropriate action is taken.
Additionally, OHA exercises oversight of Medicaid/CHIP programs by employing designated staff to partner with 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

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).

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.
Audit staff from the Department of Human Services and the Secretary of State's Office 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. Audits are conducted on a schedule determined by DHS Auditing Staff and the Secretary of State's Office.
DHS auditors 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 CPAs (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 otential 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 contact terms; safeguarding assets, adequacy of internal controls; sound fiscal practices; effective management systems; and security and controls of information systems.
Secretary of State Audits: The Audits Division is responsible for carrying out the duties of the Secretary of State's Office as the constitutional Auditor of Public Accounts. The Audits Division is the only independent auditing organization in the state with the authority to review programs of agencies in all three branches of state government and other organizations receiving state money. Authority for the responsibilities of the Audits Division is found in sections 297.00 through 297.990 of the Oregon Revised Statutes. Secretary of State auditors review the areas of finance, performance, information technology, and fraud and abuse. Frequency of SOS audits is based on risk assessment and on standards established by nationally-recognized entities including, but not limited to, the GAO and the National Association of State Auditors. Types of audits include: Financial and compliance audits of all components of state government and state-aided institutions. These audits determine whether a state agency has conducted its financial operations properly and has presented its financial statements in accordance with generally accepted accounting principles. Examinations of internal control structures and determine whether state agencies have complied with finance-related legal requirements. At the end of each engagement, the Division prepares an opinion regarding financial statements, reports significant finds, and recommends any necessary improvements.
Financial and compliance audits of the state’s annual financial statements: This audit, the largest audit of public funds in the state and a major engagement of the Division, complies with the Single Audit Act of 1984 (PL 92-502) which requires such an audit annually as a condition of eligibility for Federal funds:
~ Performance audits of the operations and results of state programs determine whether the programs are conducted in an economical and efficient manner;
~ Special studies and investigations regarding misuse of state resources or inefficient management practices;
~ Requested audits or special studies for counties.
In accordance with statutory provisions and in cooperation with the State Board of Accountancy and the Oregon Society of Certified Public Accountants, the Division: develops the standards for conducting audits of all Oregon municipal corporations; prescribes, revises, and maintains minimum standards for audit reports; and reviews reports, certificates, and procedures for audits and reviews of corporations. The Division evaluates reports of audits or reviews of these municipal corporations and auditor's work papers for compliance with the standards. In addition to audit activities of the DHS Audit Unit and Secretary of State Audit Division.
The OHA, 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.

**In reference to the waiver service Supported Employment - Individual Employment Support, Oregon will reconcile the Federal Financial Participation (FFP), in aggregate, for Job Coaching (Initial and On-going) dating back to September 1, 2014, when the rates were implemented. Oregon will use the Employment Outcome Survey (EOS) data that will be collected in May 2015, and on a monthly basis thereafter, to track Job Coaching direct contact time, by individual.
We will compare data collected on job coach direct contact to data collected on the amount of hours individuals worked to complete comparisons to the Tier assumptions. The variance/difference will be reconciled according to rates and information below:
For example, if the percentage of actual direct service time for Tier 1 is 40% (and not 50% as estimated), Oregon will apply 40% to the initial, Tier 1 rate of $55.93 to come up with a final rate of $22.37 (rather than the estimated rate of

$27.97) for Tier 1. We would then reduce each hour of service that we billed CMS for by $5.60 ($27.97 - $22.37 = $5.60). Each Tier will be aggregated using the coinciding rate for that Tier, dating back to September 1, 2014 with the adjustment made on the CMS 64.

Initial Job Coaching Example

Tier	Direct Support Rate	Estimated percent Direct Service Time	Actual Percent Direct Service Time	Interim rate Based on Hours of Paid Employment	Final rate Based on Hours of Paid Employment
1	$55.93	50%	40%	$27.97	$22.37
2	$56.56	70%		$39.59	
3	$57.80	90%		$52.02	
4	$59.74	100%		$59.74	
5	$62.52	100%		$62.52	
6	$66.37	100%		$66.37	

Ongoing Job Coaching Example

Tier	Direct Support Rate	Estimated percent Direct Service Time	Actual Percent Direct Service Time	Interim rate Based on Hours of Paid Employment	Final rate Based on Hours of Paid Employment
1	$47.50	45%		$21.38	
2	$48.02	55%		$26.41	
3	$49.05	75%		$36.79	
4	$50.67	100%		$50.67	
5	$53.01	100%		$53.01	
6	$56.25	100%		$56.25	

This same reconciliation process will be completed for each Tier and the final adjustment of all Tiers will be reflected on the CMS 64 report in future quarters. Oregon will, in aggregate, adjust its FFP request to reflect the actual percentage of direct service time in comparison to hours worked by the individual. This is not auditing related reconciliation and the system will process the adjustment as a Prior Period adjustment on lines 8 and 10b.
A rate setting firm will be under contract and will work with ODDS, OHA and, as appropriate CMS, to develop a final, approvable rate methodology. That methodology will be completed and the associated Waiver amendments will be submitted for expected implementation no later than January 1, 2016. Oregon will not implement this new methodology until it is approved by CMS.**

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(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:
PM34: 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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):

Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM35: Number and percent of waiver case management billable claims paid as specified in the approved waiver N: Number of claims appropriately coded and paid for in accordance with the reimbursement methodology. D: Total number of claims coded and paid for.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	

		☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: biennially	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated

	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

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

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:
PM36: 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.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: OHA will review 10% sample of County operated
	☐ **Other** Specify:	

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):*
	☐ **Weekly**	☐ **100% Review**

☑ **State Medicaid Agency**		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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. Non-compliance will be determined by any performance measure that falls below 86% accuracy.
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)
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*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rates guidelines for all waiver services are established and published by the Department. Costs of services are estimated based upon DHS-published allowable rates and other limitations imposed by Oregon Administrative Rule. Rates must comply with Oregon's minimum wage standards.
Wages for Personal Support Workers are established in the Collective Bargaining Agreement (CBA). Adjustments to wages are legislatively approved and negotiated through the CBA process. CBAs are negotiated biennially. The Department applies cost of living adjustments as required by legislative mandates or other CBA. The rates do not include employee benefits, room and board administrative costs, or other indirect costs.
For Employment Path Services, Small Group Employment Support and day service rates for provider organizations, the DHS ReBAR program based these rate models on stakeholder input, market rates, and other requirements imposed by Oregon Administrative Rule (OAR). Additional information included a comparison of workers in comparable fields, based on Bureau of Labor Statistics data from May, 2012.
Provider organization rates for Employment Path Services and Small Group, are reimbursed based on an hourly rate. The reimbursable hourly rates are tied to funding tiers. Individuals are assigned a funding tier based on the functional needs assessment that includes information about the person's support needs, as well as any exceptional medical or behavioral support needs.
*For provider organizations of Individual Employment Support Job Coaching, Job Development and Discovery/Career Exploration Services, DHS contracted with Burns and Associates, to collect cost data to inform and develop rate models. This included ensuring the rates support the Employment First goals.
Rate models are based on stakeholder input, market rates, productivity assumptions (with comparison to Provider survey results), program support, and local administrative and benefit costs, and other requirements imposed by

Oregon Administrative Rule.
Information also included a comparison of workers in comparable fields, based on Bureau of Labor Statistics data from May, 2015 and intensity of supports based on the supported individual's level of need, group size, service setting and staff qualification and training requirements.

Provider organization rates for Individual Employment Support Job Coaching are reimbursed on an hourly rate based on the hours the supported individual works. In order to bill to job coaching a job coach must provide direct contact time each month. The direct contact time must be provided in alignment with ODDS policy and the ISP. The direct contact provided will be collected through our billing system, Plan of Care, and reported in our Employment Outcomes System.
The hourly rates are tied to funding tiers. There are higher rates for individuals with more significant needs due to a higher ratio of support hours to work hours and the need for more indirect support. Individuals are assigned a funding tier based on the functional needs assessment that includes information about the person's support needs, as well as any exceptional medical or behavioral support needs.
There are 6 Tier levels grouped into Categories.
• Category 1 consists of individuals assessed at the Tier 1 level,
• Category 2 consists of individuals assessed at the Tier 2 and 3 level and
• Category 3 consists of individuals assessed at the Tier 4-6 level.
Those assessed as a Tier 7 would continue to have an exceptional rate.
Job Coaching rates vary based on the individual's number of months on the job and include Initial, Ongoing and a Maintenance rate. The Initial rate provides a higher rate for the first six months of employment, Ongoing allows a member to be stabilized over the next 18 months and Maintenance assumes less support is required after 24 months of job coaching. These timelines are implemented retrospectively.
To bill job coaching through Plan of Care a provider must enter the hours the individual works as well as the hours of direct support. Record of this must be maintained by the provider in the form of timesheets, paystubs, and progress notes. ODDS also completes a bi-annual census in which we review hours of direct support provided and verify billing data. Any change in either direction of 10% or more would result in a rate adjustment. CDDPs and Brokerages monitor employment supports by authorizing the service in their Person Centered Service Plan (including supports required), monitoring these supports and reviewing invoices to verify billing.
Discovery and Job Development are reimbursed on an outcome basis with rates varying by level of need. Specific to Discovery, based on the provider survey and through the rate setting process it has been made clear that more hours are required to complete a Discovery Profile for someone with more significant needs.
The Discovery rate is based on direct staff hourly wages, employee benefits, productivity assumptions, operating days adjustment, mileage, and administrative support.
• Category 1 assumes that the process takes 35 hours,
• Category 2 assumes 40 hours and
• Category 3 assumes 45 hours.

The following criteria must be met in order for the Discovery Service's one time outcome payment to occur:
• A Discovery Profile must be completed in a template that has been approved by ODDS.
• The completed Profile must include all information requested in the Department-approved Profile that pertains to the individual.
• The service coordinator or personal agent must review and approve the Profile to ensure it is complete, accurate, and includes all information the provider agreed to obtain under the terms of the ISP and service agreement. The service coordinator or personal agent will also verify whether any requested work experiences were completed.
• A referral to vocational rehabilitation services is an expected outcome of this service, but it is not required for payment. If the individual and his or her ISP team determine that a referral to vocational rehabilitation services is not appropriate, that decision is included in the Career Development Plan, part of the person-centered service plan. As when a referral is made, the Discovery Profile must still be completed and approved by the service coordinator or personal agent in order for payment of the Discovery service to occur.

Job Development outcome payments are made in two increments. Each of the two outcome payments is for a separate and distinct outcome. The first payment is approved by the service coordinator or personal agent upon job placement and the second is approved after the individual has retained the job for 90 calendar days.
For the job placement outcome payment to occur, the job developer must support the individual in obtaining individual integrated employment that pays minimum wage or better. The job placement must also meet any wage, hour or other job criteria identified as part of Career Development Planning or Individual Support Planning, and written into the ISP/CDP and service contract. The service coordinator or personal agent will approve the initial

placement outcome payment upon verification that the job meets the criteria established.
For the second outcome payment to occur, the individual must retain the developed job for 90 calendar days. The service coordinator or personal agent must verify that the job has been retained for 90 calendar days, and will then approve the second outcome payment. Job Development is only funded through ODDS when Vocational Rehabilitation is not able to provide the service. For that reason, ODDS has made an effort to better align our Job Development rates with the VR Job Placement rates. Based on this, and the information gathered from the provider surveys it was determined that the initial placement rate would be slightly higher than the 90-day retention rate as the data indicates that job placement typically takes more time than retention.*

Direct nursing waiver services payments are based on a state-wide fee schedule based on community wages set in 1993 with periodic CPI increases within the State of Oregon Medical Assistance Program for private duty nursing.

Family Training – Conferences and Workshops: the actual cost of enrollment fees and educational materials.

Fiscal intermediaries are compensated for operating costs based on an agreed upon monthly amount. Components of the operating cost agreed upon for monthly reimbursed amounts for fiscal intermediaries include (but is not limited to): establish and maintain an employer file for each individual, containing, at a minimum, contact information and federal and state tax records; provide assistance in registering an individual as an employer of "domestic service" workers; provide assistance to individuals in registering with contractor as a purchaser of services or supplies and designating contractor as the paying agent for the individual; establish and maintain a payroll record for each PSW; obtain information necessary to calculate tax withholdings; process and make payments to PSWs; calculate withholding; withhold and transmit to the appropriate agency, all taxes and fees imposed on the PSW; annually generate and distribute to all PSWS paid by the contractor during the prior calendar year W-2s, wage and tax statements and related documentation; consult with DHS on necessary activities and process to comply with new federal Department of Labor regulations; file all federal, state and local tax documentation with respect to the employment of PSWs; cancel and reissue a payment to a PSW if necessary; issue final payment when employment has terminated; provide DHS with a written report listing payments made by the FI provide copies of the Employee and Vendor enrollment forms upon request; and submit a monthly written report of all fair share and union dues withheld from PSWs and Vendor payments.

Environmental Safety Modifications, Specialized Medical Equipment, and Vehicle Modifications are the actual, most cost-effective price for the product offered through appropriate vendors.

Waiver Case Management: Oregon will pay for qualifying waiver case management (WCM) activities on a per-contact-per-day methodology. Oregon will limit payment to one waiver case management contact per individual per day. If two distinct, qualifying waiver case management contacts are provided to a single individual in a single day, Oregon will only pay for one waiver case management contact for that individual.
The agency's state-wide rates were set as of 07/01/2009 and are effective for services on or after that date. The fee schedule and any annual/periodic adjustments to the fee schedule are published on the department's website at http://www.oregon.gov/DHS/spd/provtools/. The waiver case management rate is derived using the following formula: Total cost to DHS, ODDS to provide waiver case management divided by projected biennial case management contacts.
The total cost to DHS of providing waiver case management includes:
• Waiver case management staff salary and other personnel expenses;
• Supervisory salary and other personnel expenses in support of WCM services; and
• Indirect expenses (General government service charges, worker's comp, property insurance, etc).
The sum of these expenses is then multiplied by a percentage determined by the Legislature. ODDS will monitor waiver case management utilization to ensure services are being administered economically and efficiently. Adjustments to the waiver case management rate may be made periodically during the biennium if waiver case management contacts are materially different from beginning-of-biennium projections.
New waiver case management contact rates will be established at the beginning of each state biennium period using this same methodology.

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:

Provider billings for Waiver services flow directly to the DHS Express Payment and Reporting System (eXPRS) and are paid through the State Financial Management Application or SFMA once the billing claim has been validated.

The eXPRS payment system is an electronic, web-based system that manages all aspects of client enrollment, rate authorization, provider claims and billing, and subsequent reports related to those functions for these services paid through eXPRS. Payment for validated claims is made directly back to the Provider of service.

Reports are sent monthly to CDDPs. DHS maintains this information in a computerized data base, and reconciles the information monthly and annually to provider payment information maintained in DHS accounting records. This document trail allows tracking of all waiver funds to individual clients.

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) For Waiver Case Management, Family Training, Supported Employment and Discovery/Career Exploration services the eXPRS payment system interfaces with the MMIS recipient subsystem and updates a client's Medicaid and service eligibility daily. The service provider enters the claim into eXPRS, the MMIS recipient subsystem is checked to verify the individual's Medicaid and waiver eligibility. If eligibility is confirmed, payment is made. If an individual is not eligible for a Waiver service for the date(s) of service, the payment claim is suspended. There is no possibility of payment duplications within the eXPRS system.

If an individual is not eligible for a Waiver service on the date(s) of service, payment can be made using State General Fund dollars only.

b) For all waiver services, the CDDP authorizes the specific services to be provided in the individual support plan (ISP) (or plan of care). Providers receive a copy of the ISP, specifying the services to be provided prior to the provision of services. The ISP must be signed and authorized using the following standards:
*** The ISP addresses the needs of the individual as defined in Oregon Administrative Rules;
*** The ISP identifies type, amount, frequency, duration and provider of services. *** The ISP is signed by the individual (if able) or his or her guardian, (if any), and other team members where applicable;

Waiver Case Management, Family Training, Supported Employment and Discovery/Career Exploration services must also have an accepted (active) client prior authorization (CPA) in eXPRS prior to payment. For services authorized and paid via eXPRS, the CDDP must create and submit the CPAs in eXPRS which authorizes the expenditure of Department funds. For these waiver services paid through eXPRS, the CPA establish permission to expend funds for client services and establish a limit on DHS payments. After a service has been delivered, the Provider submits a payment claim via eXPRS. The system checks the claim against the prior authorizations, client eligibility, and if the claim complies with all authorizations, payment is made to the provider.

c) Waiver Case Management, Supported Employment and Discovery/Career Exploration payments are made post delivery of service via the eXPRS payment system. Providers can only submit claims for payment after the service is delivered (the system will not allow any prospective claims). The authorization of client services in eXPRS is managed by the CDDP.

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:

Service authorization-enrollments and payments will be managed for all waiver services via the Express Payment and Reporting System (eXPRS). CDDPs are required to maintain required documentation external to eXPRS to support the authorization of the service, client service need and preference, and the applicable rate setting methodology or tool. Service delivery providers are required to maintain external to eXPRS documentation of service delivery to support claims submitted and payment received for services rendered.

○ **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

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:

Services Coordinators employed by CDDPS and DHS, ODDS provide waiver case management services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- (●) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ( ) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- (●) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

OHA contracts directly with 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.
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 contact terms; safeguarding assets, adequacy of internal controls; sound fiscal practices; effective management systems; and security and controls of information systems.
Secretary of State Audits: The Audits Division is responsible for carrying out the duties of the Secretary of 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.**

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*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

DHS applies for SSI benefits for all children who reside in Developmental Disability(DD) Foster Care homes. A percentage of the children are in the custody of the courts and legal guardianship has been ordered to the Department of Human Serivces (DHS), Child Welfare (CW). Upon entry into child welfare foster care, a child's living situation and family financial circumstances are evaluated by CW to determine eligibliity for Title IV-E (IV-E) foster care maintenance funding. CW's Integrated Information System (IIS) holds all IV-E eligibility information for children in the care and custody of the State.

When a child is identified as having DD, his or her service case is transferred to DHS, DD Program. CW retains responsibility for the family case including reunification, permanency and protection from familial abuse. The child's case management is DD Program's responsibility.

DHS, DD Program utilizes Title IV-E as a source of funding for a portion of DHS' DD Program's initial rate for eligible children residing in DD foster care homes. DHS uses Oregon Administrative Rules 413-090-0000 through 413-090-0050 as established by DHS CW and CW's Foster Care Maintenance Payment Rate Reimbursement Methodology to identify the Title IV-E payment amount for children receiving services paid through DHS, DD Program. Base rate payments are based on maintenance payments for children in CW's care and custody. Of a child's Title IV-E payment, a predetermined amount, identified in OAR and the Rate Reimbursement Methodology, covers basic supervision. The monthly IV-E foster care maintenance payment (IV-E payment) includes a child's room, board and basic supervision.

DHS, DD Program applies for SSI on behalf of children receiving services. SSI reduces its benefit by the amount of the child's IV-E payment on a dollar for dollar basis. DHS, DD Program uses the difference between the IV-E payment and the SSI standard to establish the amount of each child's Personal Incidental Fund. For children who do not qualify for SSI, the difference between the IV-E monthly maintenance payment and the SSI standard may be paid using DD Program's General Fund Budget.

DHS, DD Program bills IV-E for the IV-E payment using the same Program Cost Account (PCA) code used by Child Welfare when they bill IV-E for children in their care and custody who do not have DD. This allows the PCA that goes through to the State Financial Management & Accounting (SFMA) system to attribute the payment to the CW budget.

A Memorandum of Understanding (MOU) has been constructed between DD Program and Child Welfare allowing DD Program to access IV-E foster care maintenance funds for eligible children with CW acting as a "pass through."

The child's DD service payment will be billed to TXIX using the same processes as are currently in place. This service payment pays for activities that are always above and beyond the basic supervision covered by the IV-E payment, as identified on the child's ISP.

For children not eligible for IV-E, Medicaid does not pay the cost of room and board, or basic supervision covered by IV-E. Room, board and supervision are covered by an individual's SSI, SSB, SSDI, Veteran's Benefit or other source of income that are not Medicaid waiver funds. If an individual does not have sufficient income to pay the

costs of room and board, sources other than Medicaid, such as State general fund dollars, are used. TXIX is billed for the remaining service payment after room and board has been paid by other funding sources as described above.

For individuals residing Adult Foster Care homes, Medicaid does not pay the cost of room and board. Room and board is covered by an individual's SSI, SSB, SSDI, Veteran's Benefit or other source of income that are not Medicaid waiver funds. If an individual does not have sufficient income to pay the costs of room and board, sources other than Medicaid, such as State general fund dollars, are used. TXIX is billed for the remaining service payment after room and board has been paid by other funding sources as described above.

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: ICF/IID

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	5341.97	7128.00	12469.97	133116.00	4353.36	137469.36	124999.39
2	5458.00	7484.00	12942.00	133548.00	4485.86	138033.86	125091.86
3	5895.05	7858.00	13753.05	133980.00	4485.86	138465.86	124712.81
4	5815.74	8251.00	14066.74	134411.00	4768.11	139179.11	125112.37
5	5985.07	8664.00	14649.07	134735.00	4885.36	139620.36	124971.29

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:
		ICF/IID
Year 1	14640	14640
Year 2	14750	14750
Year 3	14900	14900
Year 4	15120	15120
Year 5	15320	15320

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.

Based upon most recent 372 report the average length of stay is 340 days.

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:

Using actuals from most recent 372 report, inflated forward and considering legislatively authorized increases in provider rates. **The component services are calculated using an average cost per unit.** **The D' calculation for the Comp Services Waiver projections are based on a 5% inflation rate based on the Appendix J figures from the prior waiver period inflated forward.**

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' derived from actual expenditures reported on most recent 372 report, inflated forward. 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 basis of these expenditures is from actual resident expenditures during the last year of operation of Oregon's last ICF/IDD. This facility closed in 2010. Factor G has been historically projected using Eastern Oregon Training Center as the basis for the projections. Eastern Oregon Training Center closed in 2009. Actual expenditures from 2009 have been the basis of the Factor G numbers inflated forward.

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:

*Oregon has adjusted the projections is Appendix J-2-c for the estimate of G'. Since Oregon has no ICF/ID institutional settings in-state, Oregon is using a combined average of the G' estimates from Washington and Idaho 1915(c) waivers for the ICF/ID population. The appendix G' estimates assume that individuals requiring or requesting institutional services would be served in one of these states. Factor G' is established using an average of the Appendix J-2-c projections from both of these states using their inflation factors.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Employment Path Services	
Supported Employment - Individual Employment Support	
Waiver Case Management	
Direct Nursing	
Discovery/Career Exploration Services	
Environmental Safety Modifications	
Family Training - Conferences and Workshops	
Financial Management Services	
Specialized Medical Supplies	
Supported Employment - Small Group Employment Support	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

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

d. **Estimate of Factor D.**

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Path Services Total:							**6224400.00**
Employment Path Services	☐	hours	1425	260.00	16.80	**6224400.00**	
Supported Employment - Individual Employment Support Total:							**4956120.00**
Job Development Placement	☐	outcome	0	0.00	1977.20	**0.00**	
Job Development Retention	☐	outcome	0	0.00	1235.75	**0.00**	
Job Coaching Initial	☐	hours	0	0.00	33.40	**0.00**	
Job Coaching Ongoing	☐	hours	0	0.00	26.75	**0.00**	
Job Coaching Maintenance	☐	hours	0	0.00	21.21	**0.00**	
Job Coaching	☐	hours	305	260.00	54.00	**4282200.00**	
Job Development	☐	outcome	160	1.00	4212.00	**673920.00**	
Waiver Case Management Total:							**62819830.08**
Waiver Case Management	☐	Encounter	14640	27.60	155.47	**62819830.08**	
Direct Nursing Total:							**0.00**
Direct Nursing	☐	quarter hour	0	0.00	6.95	**0.00**	
Discovery/Career Exploration Services Total:							**256000.00**
Discovery/Career Exploration Services	☐	outcome	160	1.00	1600.00	**256000.00**	
Environmental Safety Modifications Total:							**5000.00**
Environmental Safety Modifications	☐	event	2	1.00	2500.00	**5000.00**	
Family Training - Conferences and Workshops Total:							**1725.00**
Family Training - Conferences and Workshops	☐	event	5	5.00	69.00	**1725.00**	

GRAND TOTAL:	**78206435.08**
Total: Services included in capitation:	
Total: Services not included in capitation:	78206435.08
Total Estimated Unduplicated Participants:	**14640**
Factor D (Divide total by number of participants):	**5341.97**
Services included in capitation:	
Services not included in capitation:	5341.97
Average Length of Stay on the Waiver:	340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services Total:							**157500.00**
Financial Management Services	☐	monthly	375	12.00	35.00	**157500.00**	
Specialized Medical Supplies Total:							**75600.00**
Specialized Medical Supplies	☐	purchase	60	12.00	105.00	**75600.00**	
Supported Employment - Small Group Employment Support Total:							**3672760.00**
Supported Employment - Small Group Employment Support	☐	hours	700	260.00	20.18	**3672760.00**	
Vehicle Modifications Total:							**37500.00**
Vehicle Modifications	☐	event	5	1.00	7500.00	**37500.00**	

GRAND TOTAL:	**78206435.08**
Total: Services included in capitation:	
Total: Services not included in capitation:	78206435.08
Total Estimated Unduplicated Participants:	**14640**
Factor D (Divide total by number of participants):	**5341.97**
Services included in capitation:	
Services not included in capitation:	5341.97
Average Length of Stay on the Waiver:	340

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Path Services Total:							**5787600.00**
Employment Path Services	☐	hours	1325	260.00	16.80	**5787600.00**	

GRAND TOTAL:	**80503212.00**
Total: Services included in capitation:	
Total: Services not included in capitation:	80503212.00
Total Estimated Unduplicated Participants:	**14750**
Factor D (Divide total by number of participants):	**5458.00**
Services included in capitation:	
Services not included in capitation:	5458.00
Average Length of Stay on the Waiver:	340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Individual Employment Support Total:							**6739200.00**
Job Development Placement	☐	outcome	0	0.00	1977.20	**0.00**	
Job Development Retention	☐	outcome	0	0.00	1235.75	**0.00**	
Job Coaching Initial	☐	hours	0	0.00	33.40	**0.00**	
Job Coaching Ongoing	☐	hours	0	0.00	26.75	**0.00**	
Job Coaching Maintenance	☐	hours	0	0.00	21.21	**0.00**	
Job Coaching	☐	hours	405	260.00	54.00	**5686200.00**	
Job Development	☐	outcome	250	1.00	4212.00	**1053000.00**	
Waiver Case Management Total:							**63291837.00**
Waiver Case Management	☐	Encounter	14750	27.60	155.47	**63291837.00**	
Direct Nursing Total:							**0.00**
Direct Nursing	☐	quarter hour	0	0.00	6.95	**0.00**	
Discovery/Career Exploration Services Total:							**408000.00**
Discovery/Career Exploration Services	☐	outcome	250	1.00	1632.00	**408000.00**	
Environmental Safety Modifications Total:							**11000.00**
Environmental Safety Modifications	☐	event	4	1.00	2750.00	**11000.00**	
Family Training - Conferences and Workshops Total:							**2625.00**
Family Training - Conferences and Workshops	☐	event	7	5.00	75.00	**2625.00**	
Financial Management Services Total:							**168000.00**
Financial Management Services	☐	monthly	400	12.00	35.00	**168000.00**	
Specialized Medical Supplies Total:							**193200.00**

GRAND TOTAL:	**80503212.00**
Total: Services included in capitation:	
Total: Services not included in capitation:	80503212.00
Total Estimated Unduplicated Participants:	**14750**
Factor D (Divide total by number of participants):	**5458.00**
Services included in capitation:	
Services not included in capitation:	5458.00
Average Length of Stay on the Waiver:	340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Supplies	☐	purchase	80	23.00	105.00	193200.00	
Supported Employment - Small Group Employment Support Total:							3864250.00
Supported Employment - Small Group Employment Support	☐	hours	725	260.00	20.50	3864250.00	
Vehicle Modifications Total:							37500.00
Vehicle Modifications	☐	event	5	1.00	7500.00	37500.00	
					GRAND TOTAL:		80503212.00
					Total: Services included in capitation:		
					Total: Services not included in capitation:		80503212.00
					Total Estimated Unduplicated Participants:		14750
					Factor D (Divide total by number of participants):		5458.00
					Services included in capitation:		
					Services not included in capitation:		5458.00
					Average Length of Stay on the Waiver:		340

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Path Services Total:							5350800.00
Employment Path Services	☐	hours	1225	260.00	16.80	5350800.00	
Supported Employment - Individual Employment Support Total:							4018089.35
Job Development Placement	☐	outcome	1	1.00	1977.20	1977.20	
					GRAND TOTAL:		87836176.95
					Total: Services included in capitation:		
					Total: Services not included in capitation:		87836176.95
					Total Estimated Unduplicated Participants:		14900
					Factor D (Divide total by number of participants):		5895.05
					Services included in capitation:		
					Services not included in capitation:		5895.05
					Average Length of Stay on the Waiver:		340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Job Development Retention	☐	outcome	1	1.00	1235.75	1235.75	
Job Coaching Initial	☐	hours	35	307.40	40.38	434448.42	
Job Coaching Ongoing	☐	hours	149	383.80	34.58	1977498.80	
Job Coaching Maintenance	☐	hours	149	383.80	28.03	1602929.19	
Job Coaching	☐	hours	0	0.00	54.00	0.00	
Job Development	☐	outcome	0	0.00	4212.00	0.00	
Waiver Case Management Total:							**73111320.00**
Waiver Case Management	☐	Encounter	14900	28.20	174.00	73111320.00	
Direct Nursing Total:							**377329.40**
Direct Nursing	☐	quarter hour	49	1108.00	6.95	377329.40	
Discovery/Career Exploration Services Total:							**577083.20**
Discovery/Career Exploration Services	☐	outcome	304	1.00	1898.30	577083.20	
Environmental Safety Modifications Total:							**15000.00**
Environmental Safety Modifications	☐	event	5	1.00	3000.00	15000.00	
Family Training - Conferences and Workshops Total:							**16065.00**
Family Training - Conferences and Workshops	☐	event	5	42.00	76.50	16065.00	
Financial Management Services Total:							**178500.00**
Financial Management Services	☐	monthly	425	12.00	35.00	178500.00	
Specialized Medical Supplies Total:							**108240.00**
Specialized Medical Supplies	☐	purchase	82	12.00	110.00	108240.00	
Supported Employment - Small Group Employment Support Total:							**4046250.00**
						4046250.00	

GRAND TOTAL:	**87836176.95**
Total: Services included in capitation:	
Total: Services not included in capitation:	87836176.95
Total Estimated Unduplicated Participants:	**14900**
Factor D (Divide total by number of participants):	**5895.05**
Services included in capitation:	
Services not included in capitation:	5895.05
Average Length of Stay on the Waiver:	340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Small Group Employment Support	☐	hours	750	260.00	20.75		
Vehicle Modifications Total:							**37500.00**
Vehicle Modifications	☐	event	5	1.00	7500.00	**37500.00**	
					GRAND TOTAL:		**87836176.95**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		87836176.95
					Total Estimated Unduplicated Participants:		**14900**
					Factor D (Divide total by number of participants):		**5895.05**
					Services included in capitation:		
					Services not included in capitation:		5895.05
					Average Length of Stay on the Waiver:		340

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Path Services Total:							**4914000.00**
Employment Path Services	☐	hours	1125	260.00	16.80	**4914000.00**	
Supported Employment - Individual Employment Support Total:							**4018089.35**
Job Development Placement	☐	outcome	1	1.00	1977.20	**1977.20**	
Job Development Retention	☐	outcome	1	1.00	1235.75	**1235.75**	
Job Coaching Initial	☐	hours	35	307.40	40.38	**434448.42**	
Job Coaching Ongoing	☐	hours	149	383.80	34.58	**1977498.80**	
					GRAND TOTAL:		**87934011.45**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		87934011.45
					Total Estimated Unduplicated Participants:		**15120**
					Factor D (Divide total by number of participants):		**5815.74**
					Services included in capitation:		
					Services not included in capitation:		5815.74
					Average Length of Stay on the Waiver:		340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Job Coaching Maintenance	☐	hours	149	383.80	28.03	1602929.19	
Job Coaching	☐	hours	0	0.00	54.00	0.00	
Job Development	☐	outcome	0	0.00	4212.00	0.00	
Waiver Case Management Total:							**74190816.00**
Waiver Case Management	☐	Encounter	15120	28.20	174.00	74190816.00	
Direct Nursing Total:							**469736.60**
Direct Nursing	☐	quarter hour	61	1108.00	6.95	469736.60	
Discovery/Career Exploration Services Total:							**577083.20**
Discovery/Career Exploration Services	☐	outcome	304	1.00	1898.30	577083.20	
Environmental Safety Modifications Total:							**24000.00**
Environmental Safety Modifications	☐	event	8	1.00	3000.00	24000.00	
Family Training - Conferences and Workshops Total:							**16386.30**
Family Training - Conferences and Workshops	☐	event	5	42.00	78.03	16386.30	
Financial Management Services Total:							**189000.00**
Financial Management Services	☐	monthly	450	12.00	35.00	189000.00	
Specialized Medical Supplies Total:							**112200.00**
Specialized Medical Supplies	☐	purchase	85	12.00	110.00	112200.00	
Supported Employment - Small Group Employment Support Total:							**3385200.00**
Supported Employment - Small Group Employment Support	☐	hours	775	260.00	16.80	3385200.00	
Vehicle Modifications Total:							**37500.00**
Vehicle Modifications	☐	event				37500.00	

GRAND TOTAL:	**87934011.45**
Total: Services included in capitation:	
Total: Services not included in capitation:	87934011.45
Total Estimated Unduplicated Participants:	**15120**
Factor D (Divide total by number of participants):	**5815.74**
Services included in capitation:	
Services not included in capitation:	5815.74
Average Length of Stay on the Waiver:	340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			5	1.00	7500.00		
				GRAND TOTAL:			87934011.45
				Total: Services included in capitation:			
				Total: Services not included in capitation:			87934011.45
				Total Estimated Unduplicated Participants:			15120
				Factor D (Divide total by number of participants):			5815.74
				Services included in capitation:			
				Services not included in capitation:			5815.74
				Average Length of Stay on the Waiver:			340

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Path Services Total:							**4477200.00**
Employment Path Services	☐	hours	1025	260.00	16.80	**4477200.00**	
Supported Employment - Individual Employment Support Total:							**4018089.35**
Job Development Placement	☐	outcome	1	1.00	1977.20	**1977.20**	
Job Development Retention	☐	hours	1	1.00	1235.75	**1235.75**	
Job Coaching Initial	☐	hours	35	307.40	40.38	**434448.42**	
Job Coaching Ongoing	☐	hours	149	383.80	34.58	**1977498.80**	
Job Coaching Maintenance	☐	hours	149	383.80	28.03	**1602929.19**	
Job Coaching	☐	hours	0	0.00	4212.00	**0.00**	
Job Development						**0.00**	
				GRAND TOTAL:			**91691214.85**
				Total: Services included in capitation:			
				Total: Services not included in capitation:			91691214.85
				Total Estimated Unduplicated Participants:			**15320**
				Factor D (Divide total by number of participants):			**5985.07**
				Services included in capitation:			
				Services not included in capitation:			5985.07
				Average Length of Stay on the Waiver:			340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	☐	outcome	0	0.00	54.00		
Waiver Case Management Total:							**76771584.00**
Waiver Case Management	☐	Encounter	15320	28.80	174.00	**76771584.00**	
Direct Nursing Total:							**569844.40**
Direct Nursing	☐	quarter hour	74	1108.00	6.95	**569844.40**	
Discovery/Career Exploration Services Total:							**577083.20**
Discovery/Career Exploration Services	☐	outcome	304	1.00	1898.30	**577083.20**	
Environmental Safety Modifications Total:							**323500.00**
Environmental Safety Modifications	☐	event	10	1.00	32350.00	**323500.00**	
Family Training - Conferences and Workshops Total:							**16713.90**
Family Training - Conferences and Workshops	☐	event	5	42.00	79.59	**16713.90**	
Financial Management Services Total:							**199500.00**
Financial Management Services	☐	monthly	475	12.00	35.00	**199500.00**	
Specialized Medical Supplies Total:							**124200.00**
Specialized Medical Supplies	☐	purchase	90	12.00	115.00	**124200.00**	
Supported Employment - Small Group Employment Support Total:							**4576000.00**
Supported Employment - Small Group Employment Support	☐	hours	800	260.00	22.00	**4576000.00**	
Vehicle Modifications Total:							**37500.00**
Vehicle Modifications	☐	event	5	1.00	7500.00	**37500.00**	

GRAND TOTAL:	**91691214.85**
Total: Services included in capitation:	
Total: Services not included in capitation:	91691214.85
Total Estimated Unduplicated Participants:	**15320**
Factor D (Divide total by number of participants):	**5985.07**
Services included in capitation:	
Services not included in capitation:	5985.07
Average Length of Stay on the Waiver:	340