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 section 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:
Adults' HCBS Waiver

C. Waiver Number:OR.0375
Original Base Waiver Number: OR.0375.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/26

Approved Effective Date of Waiver being Amended: 11/01/23

2. Purpose(s) of Amendment

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

The purpose of this amendment is to:

• Appendix B-4 Eligibility Group
o Add Medicaid eligibility group 435.229 targeted low-income children under age 19.
o CMS updated the template at B-4.b to add checkboxes for Parents and other caretaker relatives (42 CFR 435.110); pregnant women (42 CFR 435.116); and children (42 CFR 435.118). For both waivers, please remove those groups from the "Other specified groups" and check the appropriate boxes in this section.
• Appendix B-7 Freedom of Choice
o Remove the following language to streamline the process for the new case management system - The individual's or legal or designated representative's signature is obtained when possible. If it is not possible to obtain their signature on the form, confirmation of the choice can be documented in the following manner: witnessed mark of the individual or legal or designated representative, letter from the legal or designated representative indicating choice, or witnessed and documented phone conversation with the individual or legal or designated representative regarding choice.
• Appendix F-1
o Change wording FROM 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. TO The case manager reviews the Notification of Rights with the individual or their guardian in their preferred format and document in a progress note.

• QIS sections throughout the waiver
o Revise Performance measures to align with new 372 format.
o Revise performance measure numbers to be consistent across all 6 waivers.
o Add CEN waiver to combined reporting with the Adult and Children’s waivers. This was previously approved in the CEN waiver but inadvertently omitted from the Adult and Children’s waivers.

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**	Main: 6-I, 7-B, 8, B
☒ **Appendix A - Waiver Administration and Operation**	QI: a-i
☒ **Appendix B - Participant Access and Eligibility**	4-b, 7-a, QI: a-i-a, a-i-c, a-ii, b-ii
☒ **Appendix C - Participant Services**	5-1, 5-2, 5-3, QI: a-i-a, a-ii, b-ii
☒ **Appendix D - Participant Centered Service Planning and Delivery**	QI: a-i-a, a-i-c, a-i-d, a-i-e, a-ii, b-ii
☐ **Appendix E - Participant Direction of Services**	
☒ **Appendix F - Participant Rights**	1-1

Component of the Approved Waiver	Subsection(s)
☒ Appendix G - Participant Safeguards	QI: a-i-a, a-i-c, a-i-d, a-ii, b-ii
☒ Appendix H	1: a-i, b-i
☒ Appendix I - Financial Accountability	QI: a-i-a, a-ii, b-ii
☐ 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:

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 section 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*):

Adults' HCBS 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.0375
Draft ID: OR.006.05.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 12/01/23
Approved Effective Date of Waiver being Amended: 11/01/23

PRA Disclosure Statement

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

Oregon's approved 1915(b)(4) waiver- "Office of Developmental Disability Services Selective Contracting 1915(b)(4) Waiver - Waiver Case Management #OR.10". Oregon limits the choice of qualified providers of Waiver Case Management services of the 0375 waiver to employees of CDDPs, Support Service Brokerages and the Office of Developmental Disability Services.

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

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

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

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

☐ **A program operated under section 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 section 1915(i) of the Act.**

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

☐ **A program authorized under section 1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID-19 pandemic and as a result of the early renewal to align waivers for consolidate reporting, a quality review report was not completed for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been submitted. Upon expiration of the Appendix K amendment, Oregon will gather data and submit the quality review in addition to any outstanding 372 reports as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 reports within 90 days up to 6 months of receiving the final quality review report and 372 report acceptance decision.

The Oregon Department of Human Services (hereinafter referred to as ODHS or the Department) operates Waiver #0375 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:
ODHS endeavors to serve individuals, aged 18 and older, in the least restrictive, most cost-effective community alternatives to ICF/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. host homes, 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 state trained assessor from the CDDP, Brokerage or ODHS will work with the individual and as applicable, their legal or designated representative to complete the level of care assessment and the initial Functional Needs Assessment.

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 Case Management Entity (CME) which could be ODHS, a Community Developmental Disabilities Program (CDDP), or a Brokerage.

Organizational Structure:
The Oregon Health Authority (OHA) is the Single State Medicaid/CHIP agency (SSMA) responsible for the administration of programs funded by Medicaid and CHIP in Oregon. The Oregon Department of Human Services (ODHS or the Department) is the
Operating Agency responsible for the operation of certain programs under Medicaid, including home and community-based waivers and Community First Choice.

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

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

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 section 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 section 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 section 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 section 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 section 1915(b) or another provision of the Act.

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

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

I. Public Input. Describe how the state secures public input into the development of the waiver:

Opportunities for public input on service performance and continuing needs are not limited to this waiver amendment process. Self-advocates, families, provider organizations and community leaders were instrumental in developing an original vision of community-based alternatives to 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.

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

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

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

Public notice and comment period provided

Public notices are sent electronically to:

The ODDS Compass Project web page, waiver section: https://www.oregon.gov/odhs/idd/Pages/waivers.aspx

The ODHS news release page: https://apps.oregon.gov/oregon-newsroom/OR/ODHS/Posts

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

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

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

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

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

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121)

and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name: Sandoe

First Name: Emma

Title: State Medicaid Director

Agency: Oregon Health Authority

Address: 500 Summer St. NE

Address 2:

City: Salem

State: **Oregon**

Zip: 97301

Phone: (503) 302-5396 **Ext:** ☐ **TTY**

Fax: (503) 373-7327

E-mail: Emma.Sandoe@oha.oregon.gov

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

Last Name: O'Keeffe

First Name: Darlene

Title: Interim Director - Office of Developmental Disabilities Services

Agency: Oregon Department of Human Services

Address: 500 Summer St NE

Address 2:

City: Salem

State: **Oregon**

Zip: 97301-1024

Phone: (503) 945-6373 **Ext:** ☐ **TTY**

Fax: (503) 373-7823

E-mail: darlene.B.Okeeffe@odhs.oregon.gov

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 section 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: Sandoe

First Name: Emma

Title: State Medicaid Director

Agency: Oregon Health Authority

Address: 500 Summer Street

Address 2:

City: Salem

State: **Oregon**

Zip: 97301

Phone: (503) 302-5396 **Ext:** ☐ **TTY**

Fax: (503) 373-7327

E-mail: Emma.Sandoe@oha.oregon.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix I-2a rate information for employment services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For the job placement outcome payment to occur, the job developer must support the individual in obtaining individual

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Oregon Department of Human Services

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella

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

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

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

Oregon Health Authority (OHA), the single state Medicaid Agency, and the Oregon Department of Human Services (ODHS), the Operating Agency, have an Interagency Agreement (IAA) that contains the following oversight functions to ensure that ODHS performs its assigned waiver operations and administrative functions in accordance with waiver requirements:
- Specifies that OHA maintains the authority on Medicaid costs.
- Specifies that OHA maintains authority for waiver applications, amendments and reporting requirements related to Medicaid waivers operated by ODHS.
- Requires that OHA and ODHS 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 ODHS 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 ODHS the responsibility for the operation of, and allowable Medicaid administrative activities for home and community-based waivers serving persons who are aged or physically disabled or have developmental disabilities.
- Specifies that OHA has final approval of administrative rules and policies promulgated by ODHS that govern the waivers and is responsible for authorizing the submission of and submitting waiver applications and amendments to CMS in order to secure and maintain existing and proposed waivers. ODHS will provide policy, information, recommendations and participation to OHA through the MOCSC.
In addition to leadership-level meetings to address guiding policy,
OHA ensures that ODHS performs assigned operational and administrative functions through the following:
o Regularly scheduled meetings of the MOCSC with staff from both OHA and ODHS to discuss:
o Information and correspondence received from CMS
o Proposed policy changes
o Waiver amendments and changes
o Data collection and quality assurance activities
o Waiver eligibility and enrollment
o Fiscal projections
o All other waiver related topics
- All policy changes related to the waivers are approved by OHA. The MOCSC will be the avenue through which policy changes are reviewed. Recommendation for approval will be provided to the Medicaid Director or designee for final approval.
- Waiver renewals, requests for amendments and 372 reports will be reviewed and 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 ODHS will meet at least twice per year to review Medicaid/CHIP-related policy. The Steering Committee will be comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of

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

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

These activities are conducted on a continuous and ongoing basis. The method and frequency for which assessment occurs is identified in Appendix A: 6 and in the QIS section of each Appendix.

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.:*

A Community Developmental Disabilities Program (CDDP) and Support Services Brokerages are case management entities (CMEs) that are responsible for planning for delivery of services, conducting functional needs assessments and Level of Care assessments and providing case management services. CDDPs also determine I/DD eligibility and conduct abuse investigations, as authorized under a 1915(b)(4) waiver for persons with intellectual disabilities or other developmental disabilities. CCCPs operate in all areas of the state under an Intergovernmental Agreement (IGA) with ODHS or a local mental health authority. ODHS retains the authority to operate as a CDDP in any county of the state as needed. Support Services Brokerages operate in all areas of the state under contract with ODHS.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

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

The Oregon Department of Human Services (ODHS) utilizes performance measures related to the six assurances and other topic areas to evaluate case management entities (CMEs). They work with participants, families, providers, and others to address both concerns raised and improvement opportunities identified. ODHS staff compiles reviews and analyzes performance data through a variety of file reviews and data reports. Corrective action/remediation plans are required as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. ODHS Central Office staff follow-up to ensure appropriate action is taken. After the two-year discovery cycle, analysis of statewide accuracy on all performance measures will be reviewed by OHA and/or ODHS Quality Management staff. The frequency of data collection, aggregation and analysis is biennial with site and file reviews conducted on an ongoing basis with reviews at each CME every two years. Statewide Remediation is an ongoing process that will occur during the discovery phase. Individual remediation will occur when corrective action is needed. System-wide remediation activities will occur every two years, when required, based on statewide discovery and analysis. Both individual and system-wide remediation activities may require a corrective action plan. The Oregon Health Authority and Oregon Department of Human Services will collaborate through inter-departmental meetings on an ongoing basis and during regularly scheduled meetings to address individual and systemic issues and remediation efforts. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving ODHS reports, documents, rules, policies and guidelines. OHA, on a continuous and ongoing basis, reviews and provides input to ODHS quality control processes for Medicaid/CHIP programs managed by the ODHS to assure proper oversight of central office and field operations. This includes ongoing review and approval of ODHS operational oversight and quality assurance activities.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☐
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☒	☒
Level of care waiver eligibility 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	☒	☒	☐

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
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: The number and percent of Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) meetings held between the operating agency (OA) and the SMA per year (MOCSC meeting agendas cover ODHS QA& QI activities). N: Number of waiver management committee meetings held between the OA and the SMA per year. D: Number of waiver management committee meetings scheduled.

Data Source (Select one):
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:

PM2: Delegated Function: The percent of CDDPs/Brokerages that needed on-site monitoring or technical assistance that received on-site monitoring or technical assistance. N: The number of CDDPs/Brokerages who received on-site monitoring or technical assistance. D: The number of CDDPs/Brokerages 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: biennially	

Data Aggregation and Analysis:

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

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

Performance Measure:
PM3: Percentage of aggregated performance measure reports, trends, and remediation efforts reviewed by OHA. N: Number of aggregated performance measure reports, trends, and remediation efforts reviewed by OHA. D: Number of aggregated performance measure reports, trends, and remediation efforts generated by ODHS.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
PM4: Percentage of oversight of waiver amendments, renewals, 372 and evidence reports. N: Number of waiver amendments, renewals, 372 and evidence reports approved by OHA prior to submission. D: Number of waiver amendments, renewals, 372 and evidence reports provided by ODHS.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

PM5: Delegated Function: The percent of CDDPs/Brokerages contracts that were monitored annually by contract specialists to verify contract compliance. N: The number of contracts with CDDPs/Brokerages that were monitored. D: The number of contracts with CDDPs/Brokerages.

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**

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:

Performance Measure:
PM6: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:

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

Data and reports gathered and created by ODHS staff during quality reviews are reviewed and analyzed on a continuous and ongoing basis by designated OHA staff, including the OHA liaison to ODHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Upon completion of OHA' analysis and review of ODHS quality assurance data and reports, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document ODHS and OHA remediation efforts.
The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and ODHS. The MOCSC meets at least quarterly to coordinate and review all mutual policy issues related to the operation and administration of the Medicaid/CHIP program including state plan amendments, waiver requests, rules, procedures, and interpretive guidance. A Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) for OHA and ODHS meets at least twice per year to review Medicaid/CHIP-related policy. The Steering Committee is comprised of executive management staff of the two agencies. The purpose of the Steering Committee is to ensure coordination of policy-related issues and delineation of responsibilities, including establishment of a strategic plan for the two agencies.
ODHS staff address individual problems with designated OHA staff on an ongoing basis and during regularly

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

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

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

be conducted using the standardized survey instruments and methods utilized during the initial discovery phase.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	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	18		☒
	☒	Intellectual Disability	18		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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	23655
Year 2	24346
Year 3	25056
Year 4	

Waiver Year	Unduplicated Number of Participants
	25788
Year 5	26541

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,including eligible members of federally recognized tribes.

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)*:

○ **Section 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)

☒ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**

☒ **Pregnant Women (42 CFR § 435.116)**

☒ **Infants and Children under Age 19 (42 CFR § 435.118)**

☒ **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 section 1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR § 435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)**

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

Specify:

All SSI related groups and the following:
435.119 age 19 or older and under age 65, and 435.145 for Children with adoption assistance, foster care, or guardianship care under title IV-E, *and 435.229 Optional targeted low-income children under 19.

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

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

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.**

Select one and complete Appendix B-5.

◉ **All individuals in the special home and community-based waiver group under 42 CFR § 435.217**

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

Check each that applies:

☐ **A special income level equal to:**

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR § 435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under section 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 section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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

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

- ○ **The following standard included under the state plan**

  Select one:

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

    (*select one*):

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

      Specify the percentage:

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

      Specify dollar amount:

  - ○ **A percentage of the Federal poverty level**

    Specify percentage:

  - ○ **Other standard included under the state plan**

    Specify:

- ○ **The following dollar amount**

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

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

  Specify:

- ◉ **Other**

  Specify:

Individuals in 24-hour residential settings maintain the SSI standard as the allowance for the needs of the waiver participant. For individuals living in their own home it is 300% of the SSI Federal Benefit Rate.

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 section 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 period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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 period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 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.

Individuals in 24-hour residential settings maintain the SSI standard as the allowance for the needs of the waiver participant. For individuals living in their own home it is 300% of the SSI Federal Benefit Rate.

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 or 42 CFR § 435.735:

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 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, Eligibility Specialists are responsible for completing initial I/DD eligibility. State-trained assessors, who may be staff of a CDDP, Brokerage or ODHS, administer the state-designed LOC evaluation, initially. State trained assessors or case managers complete the functional needs assessment and level of care every 12 months thereafter.

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:

1. Eligibility specialists who complete the review of the individual's diagnosis and records of the individual's functional impairments must have the qualifications of a: (1) Qualified Intellectual Disability Professional, defined in 42 CFR 483.430; or (2) and eligibility specialist described in OAR 411-320-0030. The minimum qualifications for an eligibility specialist are: 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 behavioral science, social science, or a closely related field and two years of human services related experience; or
Three years of human services related experience.

2. State-trained assessors who administer the LOC evaluation must have the qualifications of an assessor in OAR 411-425-0035. An assessor must have knowledge of *or be provided pre-service training on* the public service system for developmental disability services in Oregon and at least: A bachelor's degree in behavioral science, social science, or a closely related field; or A bachelor's degree in any field and one year of human services related experience, such as work providing assistance to individuals and groups with issues such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing; or (C) An associate's degree in a behavioral science, social science, or a closely related field and two years of human services related experience, such as work providing assistance to individuals and groups with issues such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing; or (D) Three years of human services *or closely* related experience, such as work providing assistance to individuals and groups with issues such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing (E)ODDS provided functional needs assessment initial training and ongoing training as needed."

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.

An individual requires ICF/IID level of care after ODHS verifies the individual has:
1. a diagnosis of an intellectual disability or a closely related condition as defined in 42 CFR §435.1010;
2. a significant impairment in adaptive behavior and requires training and support similar to an individual with an intellectual disability (only required if the individual is qualifying based on a closely related condition); and
3. substantial functional limitations in areas of major life activity, as identified by CMS in the definition of persons with related conditions in 42 CFR §435.1010 (self-care; understanding and use of language; learning; mobility; self-direction; and capacity for independent living.

A) An individual meets ICF/IID Level of Care when the individual demonstrates significant impairment in at least one area of major life activity as identified in OAR 411-317-0000 by requiring some level of assessed support in response to at least 50 percent of the questions associated with each area of major life activity. The only time this percentage would be lowered would be if an odd number of questions were included. For instance if there are 9 questions associated with self-care, the individual would need to get 4/9 or 44%; or if there were 7 applicable questions it would be 3/7 or 42%.
(B) A completed ONA shall provide a Level of Care summary that includes:
(i) The areas of major life activity an individual demonstrates significant impairment by requiring some level of assessed support in response to at least 50 percent of the associated questions and the specific questions that lead to the result; and
(ii) The areas of major life activity an individual does not demonstrate significant impairment because at least 50 percent of the associated questions in that area did not require some level of support and the specific questions that lead to the result. An individual who does not require some level of support is independent, meaning that the individual needs support with the activity fewer than 50 percent of the times the activity was performed in the previous 30 calendar days prior to the initiation of the first component of the ONA as described in subsection (c) of this section.

The diagnostic information is requested and reviewed by a CDDP eligibility specialist, trained by ODHS. OAR requires a diagnosis from a qualified professional, which is defined in OAR as: licensed clinical psychologist (Ph.D. or Psy.D.) or a medical doctor (M.D.).

An eligibility specialist reviews the applicant's documentation to confirm that there is significant impairment in adaptive behavior and requires training and support similar to an individual with an intellectual disability. The documentation reviewed includes, per OAR 411-320-0080:
- Psychological evaluations
- Physician Statements
- Adaptive Evaluations
- Other medical/psychological records
- School records

OAR requires an adaptive assessment be completed by a licensed clinical or school psychologist and defines significant impairment in adaptive behavior based on composite and domain scores.
Individuals qualifying under a condition that is closely related to intellectual disability must also require training and support that is similar to an individual with an intellectual disability, which is defined in OAR and based on an evaluation with a licensed clinical or school psychologist.
When an applicant's documentation does not confirm a significant impairment in adaptive behavior based on OAR, Oregon requires a licensed clinical or school psychologist to evaluate impairment in adaptive behavior, using a standardized assessment, such as the Vineland Adaptive Behavior Scale (VABS) or the Adaptive Behavior Assessment Scale (ABAS).
Verification of substantial functional limitations in areas of major life activity as identified by CMS in the definition of persons with related conditions in 42 CFR §435.1010 (self-care; understanding and use of language; learning; mobility; self-direction; and capacity for independent living".
Once the individual is determined to meet I/DD criteria the case manager arranges a face to face with the individual so a state-trained assessor can conduct an evaluation using a standardized tool designed by ODHS. Assessors are trained to ask beneficiaries a holistic set of questions to evaluate the individual's condition and how the individual functions at home and in the community.
Questions focus on the individual's ability to function in the following areas of major life activity: Capacity for independent living, Learning, Self-direction, Self-care, Mobility, and Understanding and use of language. The evaluation includes questions about the individual's behaviors and responses in threatening situations, ability to make independent decisions, ability to communicate and express oneself, ability to plan and access support in the community, ability to make financial decisions, medications and medical needs, need for assistance with daily living activities, and other special requirements.

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:

Initial Level of care evaluation

1. The operating agency, ODHS, uses a state developed standardized level of care evaluation tool.

2. State-trained assessors, who may be staff of a CDDP, Brokerage, or ODHS administer the state-designed LOC evaluation, initially. State trained assessors or case managers complete the functional needs assessment and level of care at a minimum of every 12 months thereafter.

ODHS provides oversight of the level of care evaluation by: providing regular, required training on how to conduct level of care evaluations; requiring state-trained assessors to meet minimum qualifications; requiring that initial level of care evaluations be submitted to ODHS for approval; and conducting quality assurance audits on a regular basis.

3. Eligibility specialists, employed at the CDDP in the individual's county or region, review the documentation to verify the individual has an intellectual disability or a closely related condition as well as functional impairments as a result of the condition. The documentation includes:
- o Psychological evaluations
- o Physician Statements
- o Adaptive Evaluations
- o Other medical/psychological records
- o School records

The eligibility criteria is listed in OAR 411-320-0080. ODHS grants the eligibility specialist authority to schedule a diagnostic evaluation with a qualified professional if the individual's documentation does not contain enough information to make an eligibility determination.

The eligibility specialist then completes a ODHS form to summarize the individual's condition, including the individual's qualifying diagnosis, intellectual functioning, and impairments in adaptive behavior.

4. Case managers employed at a CDDP or Supports Services Brokerage in the individual's county or region arrange the evaluation. State-trained assessors administer the initial evaluation. The evaluation is completed during a face-to-face interview with the individual.

5. The diagnostic information, coupled with the results of the state-designed assessment, is submitted to ODHS to make the level of care determination.
The determination is based on the diagnosis and functional impairments (whether the individual has substantial limitations in the six areas of major life activity identified by CMS in the definition of persons with related conditions in 42 CFR §435.1010 (self-care; understanding and use of language; learning; mobility; self-direction; and capacity for independent living".

The ICF/IID level of care used to support eligibility for a previous ODDS ICF/IID level of care waiver supports eligibility for this ICF/IID level of care waiver when the individual's condition has not changed, and the level of care was completed less than 12 months ago. Individuals may transition to/from the *#2386 Children's Extraordinary Needs Waiver*, #0117 Children's Waiver, #0375 Adult's Waiver, and #40194 Behavioral Model Waiver and the LOC process, criteria and evaluations are the same for each waiver referenced.

Reevaluation

1. OAR 411-415-0060(1) requires case managers to arrange a reevaluation every 12 months. The reevaluation is completed within 12 months of initial ODHS approval, and then within 12 months thereafter.

2. State-trained assessors or case managers meet face-to-face with individuals every 12 months to conduct the level of care evaluation. The assessors uses the same level of care evaluation tool described above, which is designed and maintained by ODHS.

3. A reevaluation is conducted sooner if the case manager learns of or observes a change in any condition that qualified the individual for services.

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):*

Case managers can schedule the face-to-face Level of Care reevaluation at the same time as the annual ISP meeting or at a time that is convenient for the individual and their family. The meeting must be conducted within the mandated 12-month time frame from previous re-evaluation.

Case management entities (CMEs) are given the latitude to use either a tickler file system or a computer tickler system to ensure timely scheduling of reevaluations of level of care (LOC). This is determined by technology available in each CME or the process that works best for them on an individual basis.

An individual's annual level of care reevaluation must be conducted face-to-face to ensure the health and welfare of the recipient. Completion of the level of care (LOC) reevaluation cannot exceed 12- months from the date of the last reevaluation.

ODDS QA Unit staff complete a review of Levels Of Care for a statistically valid number of individuals in the waiver.

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 are assessments will be kept, electronically, at ODHS, Central Office and will be maintained for a period that is longer than 3 years.

Case management entities also maintain both original copies of the initial level of care evaluation (when possible) and reevaluations with the individual's other service records. The service records are maintained in accordance with OAR. The OAR requires evaluations must be maintained for the length of the individual's enrollment and more than 3 years after the individual's services are terminated or the individual dies.

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:
PM7: Number and percent of new waiver applicants who had an approved initial LOC prior to waiver enrollment. N: Number of new waiver applicants who had an approved initial LOC prior to waiver enrollment. D: Total number of new waiver applicants reviewed.

Data Source (Select one):
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:
PM8: Number and percent of waiver participants who were offered the choice of institutional services. N: Number of waiver participants who were offered the choice of institutional services. D: Total number of waiver participants reviewed.

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

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

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = A random sample of the combined populations of waivers 0117, *2386, and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Bienially	

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

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

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

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

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: OHA will review a 10% sample of individual files reviewed by DHS during DHS' review of Brokerages operated by non-state entities.
	☒ **Other** Specify: Biennially	

Data Aggregation and Analysis:

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

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

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:
PM9: Number and percent of *waiver participants'* LOC that were completed based on the instruments in the approved waiver. N: Number of *waiver participants'* LOC that were completed based on the instruments in the approved waiver. 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 =

		*A random sample of the combined populations of waivers 0117, *2386, and 0375 with confidence interval = 95%/5%/50% to determine sample size.*
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: biennially	

Data Aggregation and Analysis:

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

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

Performance Measure:
PM10: Number and percent of *waiver participants'* LOC that were completed based on the processes in the approved waiver. N: Number of *waiver participants'* LOC that were completed based on the processes in the approved waiver. 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 = *A random sample of the combined populations of waivers 0117, *2386*, and 0375 with confidence interval = 95%/5%/50% to determine sample size.*
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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

The frequency of data collection, aggregation and analysis is biennial with site and file reviews conducted on an ongoing basis with reviews at each site every two years. The sample universe will be comprised of waiver year 1 and 2 for the #0117, *#2386 and #0375 waivers combined, to determine the statistically valid representative random sample size. The file review sample size used for all measures in Appendix D and two of the appendix G performance measures is based on a statistically valid representative random sample utilizing a 95% confidence level, 5% margin of error and 50% response distribution, as determined by the Raosoft sample size calculator found at http://www.raosoft.com/samplesize.html for the two-year cycle. This representative sample is proportioned across case management entities based on the percentage of the population served relative to the waiver population size. Half of the sample will be pulled for participants who were enrolled in waiver year one and the other half pulled for participants enrolled in waiver year two. Within the sample drawn each year of the biennial cycle, Oregon will over sample to account for multiple variable review, as well as to account for 'non-response' factors such as participants who are no longer enrolled in the waiver due to relocation out of state or death and participants

whose length of enrollment within the review period is insufficient to produce results for the variables measured (e.g., service plan updated annually cannot be assessed for someone who is newly enrolled for less than 12 months).

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

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

The 0117, *2386, and 0375 waivers meet the following five CMS conditions:
1. Design of the waivers is the same or very similar;
2. This sameness or similarity is determined by comparing waivers on the approved waiver application appendices: a. Participant Services,
b. Participant Safeguards, and
c. Quality Management;
3. The quality management approach is the same or very similar across waivers, including:
a. Methodology for discovering information (e.g., data systems, sample selection),
b. Manner in which individual issues are remedied,
c. Process for identifying and analyzing patterns/trends, and
d. Majority of the performance indicators are the same;
4. The provider network is the same or very similar; and
5. Provider oversight is the same or very similar.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Individual remediation activities will require follow-up by the ODHS Quality Management Staff to determine that the corrective action was successfully completed by the field office, licensing or abuse investigation unit. The results of any remediation will be submitted to an inter-departmental workgroup for discussion, data collection and reporting. When individual and/or system-wide remediation activities are warranted based on discovery and analysis, the following time frames will be used to ensure these items are remediated in a timely manner. Because ODHS is monitoring the performance of its contractors (CMEs, and service providers)

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

ODHS timelines for remediation:

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

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

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

Timelines for systemic remediation:

Required system-wide changes: If changes require revision of administrative rules, the required changes will be completed within the time frames required by the administrative rule process, including Rule Advisory Committees (including stakeholder input), Administrative rule hearings and statutory filing time frames. If system-wide changes require waiver amendments, the process will be completed at the time of approval of the waiver amendment. This will include the 30 day public and 60 day tribal input period and 90 day approval process.

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

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

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

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	Specify: ODHS-Site/file reviews conducted ongoing with on-site reviews every two years. OHA-reviews ODHS through regularly scheduled MOCSC meetings to identify trends that may require statewide QIS changes.

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Oregon assures that individuals who are eligible for services under the waiver will be informed, during the eligibility process and initial completion of the level of care evaluation, of feasible alternatives for long-term services and supports and given a choice as to which type of services they are eligible to receive. When an individual is determined to require the level of care provided in an ICF/IID, the individual or his or her legal or designated representative will be:
1) Informed of any feasible alternatives available under the waiver and Medicaid State Plan: and
2) Given the choice of either institutional or home and community-based services.

Case managers document the offer of choice on the choice form. The offer of choice is given before an individual is enrolled onto a waiver service. The choice form is used to document that the offer of choice was presented to the individual or legal or designated representative, and how they indicated their choice of service.

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 choice forms will be kept at ODHS, Central Office. Original copies of the choice form are kept by the entity that completed the choice forms and are kept by the case manager, in the consumer's file, at the CME 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

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

ODHS follows the Department of Administrative Services standards. ODHS is committed to improving the accessibility of these programs, services and activities to eligible LEP persons. When a Limited English Proficient (LEP) person attempts to access waiver services, ODHS notifies the person that language services are available. ODHS staff inform the LEP person that he or she has the option of having an interpreter without charge, or of using his or her own interpreter. Considerations are given to the circumstances of the LEP and whether there may be concerns over competency, confidentiality, privacy, or conflict of interest. ODHS staff 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 Departments website or in hard copy at the local office.

Language assistance is available for verbal communications through a contractor.

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

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

Commonly Asked Questions And Answers Regarding Executive Order 13166

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

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**		

Service Type	Service		
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	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. Employment path may also include benefits supports, training, and planning.
Services are expected to occur over a defined period of time, as outlined in each individual's ISP, and services and supports should be designed to support successful employment outcomes consistent with the individual's personal and career goals as identified in his or her ISP.

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

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

Employment Path Services may be provided in integrated community settings and fixed-site facilities and are distinguishable from non-covered vocational services by the following criteria:

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

Employment Path Services should be reviewed and considered as a component of an individual's ISP no less than 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 is 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)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Employment Path Services Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Employment Path Services

Provider Category:

Agency

Provider Type:

Employment Path Services Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Endorsement issued by the Department is also required for a certified service provider under OAR chapter 411, division 323 that has met the qualification criteria outlined in OAR 411-345-0010 -411-345-0300.

Conditions that the Department may impose on an endorsement include but are not limited to: 1. Requiring additional staff or staff qualifications;
2. Requiring additional training;
For each specific geographic service area where services shall be delivered, a Medicaid
Performing Provider Number assigned by the Department as described in OAR chapter 411, division 370.

Staff Qualifications:

1. Be at least 18 years of age;
2. Have approval to work based on current Department policy and procedures for background checks in OAR 407-007-0200 to 407-007-0370 and OAR 411-323-0050(6) of this rule;
3. Be literate and capable of understanding written and oral orders
4. Be able to communicate with individuals, physicians, 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:

ODHS

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment - Individual Employment Support

HCBS Taxonomy:

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

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:
  - Individuals working in an individualized job in an integrated setting and earning at least minimum wage;
  - 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
  - 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.
  - 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.
  - Support to the individual in identifying potential self-employment business opportunities and assistance in the development of a self-employment business plan, including potential sources of business financing and other assistance in developing and launching a business. Medicaid funds may not be used to defray the expenses associated with starting up a business.

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

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

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

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

1. Establishing links with employers, in partnership with business services, to negotiate jobs with and for specific participants to obtain an individual job in a competitive integrated employment setting in the general workforce, including customized employment or self-employment.
2. Acting as the employer's primary contact during the supported individual's first 90 days on the job.
3. Following up with the employer and providing support to the individual during the negotiation of any additional reasonable accommodations needed or identified after job placement.
4. Providing support for any additional job carving needed after job placement.
5. Finalizing job designs and job and task analyses, including special considerations for support. This includes the identification of core job functions and identification of the related and subtle skills necessary for a worker to be successful in the job.

6. Evaluating the type and amount of job-task and social-task supports necessary for employment success.
7. Initiating relationships and facilitating natural supports with families, co-workers, supervisors, and other employer contacts
8. Maintaining continued contact with the employer, supported individual, and job coach, until the job is stable and the individual has maintained employment for at least 90 days. The retention outcome payment helps ensure and set the expectation that the job developer continues to play a role during the supported individual's initial days on the job, and ensure a smooth transition to the job coach.

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

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

All supported employment service options should be reviewed and considered as a component of an individual's ISP no less than 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.).

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

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

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	Individual Employment Support Agency
Individual	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:

Agency

Provider Type:

Individual Employment Support Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Endorsement issued by the Department is also required for a certified service provider under OAR chapter 411, division 323 that has met the qualification criteria outlined in OAR 411-345-0010 -411-345-0300.

Conditions that the Department may impose on an endorsement include but are not limited to: 1. Requiring additional staff or staff qualifications;
2. Requiring additional training;
For each specific geographic service area where services shall be delivered, a Medicaid
Performing Provider Number assigned by the Department as described in OAR chapter 411, division 370.

Staff Qualifications:

1. Be at least 18 years of age;

2. Have approval to work based on current Department policy and procedures for background checks in OAR 407-007-0200 to 407-007-0370 and OAR 411-323-0050(6) of this rule;
3. Be literate and capable of understanding written and oral orders
4. Be able to communicate with individuals, physicians, 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:

ODHS issues certificate. CME verifies certificate is current.

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Individual Employment Support Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

(a) Maintain a drug-free work place;

(b) Be at least 18 years of age;

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

(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 or CME must check the license status to verify the license is current and unencumbered.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

CME/ODDS

Frequency of Verification:

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

All employment service providers are subject to the same competency-based training, qualification, and credentialing requirements. This information is verified annually by the case managers 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 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: 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;
• Coordinate with state trained assessor to who may conduct the functional needs assessment/LOC;
• Evaluation of the extent and nature of recipient's needs (medical, social, educational, and other services) and completing related documentation;
• Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
~Development (and periodic revision) of a specific care plan that:
• is based on the information collected through the assessment;
• specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
• includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
• identifies a course of action to respond to the assessed needs of the eligible individual.
~Referral and related activities:
To help an eligible individual obtain needed services including activities that help link an individual with:
• Medical, social, educational providers; or
• Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan such as making referrals to providers for needed services, and scheduling appointments for the individual.
~Monitoring and follow-up activities:

Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. The activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals to assure following conditions are met:
• Services are being furnished in accordance with the individual's care plan;
• Services in the care plan are adequate; and
• If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.
• additional monitoring as needed which may include the review of records and encounter data to ensure that needed services are provided in accordance with the individual's person-centered service plan.
• Information and assistance in support of participant direction as it pertains to 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/State trained assessors;
(vii) A timeline for obtaining needed services;
(viii) A timeline for reevaluation of the plan.
Providers of Waiver Case Management services are limited to employees of a Support Services Brokerage, 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:

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**
☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Managers
Agency	State Trained Assessors

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Waiver Case Management

Provider Category:

Agency

Provider Type:

Case Managers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Case management services are provided by employees of a CDDP, Support Services Brokerage, ODHS, Office of Developmental Disabilities Services (ODDS), or other public or private agency, contracted by a local community mental health authority or ODDS.

Each case manager must have knowledge of *or be provided pre-service training on* the public service system for developmental disabilities services in Oregon and at least:
~ A bachelor's degree in behavioral science, social science, or a closely related field; or
~ A bachelor's degree in any field AND one year of human services related experience; or
~ An associate's degree in a behavioral science, social science, or a closely related field AND two years human services related experience; or
~ Three years of human services *or closely* related experience.

Oregon Revised Statute 427.154 allows Brokerages to provide case management services only to adults residing in their own home or the home of the adult's family. Therefore, individuals residing in a 24 hour residential setting will not be offered the choice of case management services through a brokerage.

Verification of Provider Qualifications

Entity Responsible for Verification:

ODHS/CME

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Waiver Case Management

Provider Category:

Agency

Provider Type:

State Trained Assessors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

State trained assessors are employees of a Community Developmental Disabilities Program (CDDP), Brokerage, or employees of ODHS, Office of Developmental Disability Services (ODDS), or other public or private agency, contracted by a local community mental health authority or ODDS. These entities are also referred to as a case management entity.

State Trained Assessors must have knowledge of *or be provided pre-service training on* 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 *or closely* related experience.
~ODDS provided functional needs assessment initial training and ongoing training as needed.

Oregon Revised Statute 427.154 allows Brokerages to provide case management services only to adults residing in their own home or the home of the adult's family. Therefore, individuals residing in a 24 hour residential setting will not be offered the choice of case management services through a brokerage.

Verification of Provider Qualifications

Entity Responsible for Verification:

CME or ODHS

Frequency of Verification:

At time of initial employment and upon promotion of the state trained assessor.

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):*

Direct Nursing services are defined as services determined medically necessary to support an adult (21 years of age and older) with complex health management supports provided on a shift staff basis. These services include treatments, therapies, nursing interventions and skilled nursing tasks with continuous assessment & reassessment of the medical condition as part of each shift. Rules specify Direct Nursing Services must be provided on a shift staffing basis with a minimum of four hours and a maximum of sixteen hours.

Direct nursing services are for individuals 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 Direct Nursing Services Clinical Criteria form;
- 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-851-45-0030(1)(p) that is reviewed every six months or if there is a significant change in their medical status.

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 may be provided in adult day centers, employment service settings, Adult Foster Care, 24 hour residential group home Setting or homes privately owned or leased by the individual or their family.
The services under the waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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:
• 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 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.
The amount of hours available for direct nursing services is based on the following acuity levels as measured by the Direct Nursing Services Clinical Criteria form:
(a) Level 1: Score of 75 or above and on a ventilator for 20 hours or more per day = up to a maximum of 554 hours per month for direct nursing services;
(b) Level 2: Score of 70 or above = up to a maximum of 462 hours per month for direct nursing services;
(c) Level 3: Score of 65 to 69 = up to a maximum of 385 hours per month for direct nursing services;
(d) Level 4: Score of 60 to 64 = up to a maximum of 339 hours per month for direct nursing services;
(e) Level 5: Score of 50 to 59 or if an individual requires ventilation for sleeping hours = up to a maximum of 293 hours per month for direct nursing services;
(f) Level 6: Score of 45 to 49 = up to a maximum of 140 hours per month for direct nursing services.
The criteria encompasses a review of “Care Elements” that are nursing/medical tasks across major body/biological systems of Respiration, Neurological, Vascular, Metabolic, Urinary/Kidney, Gastro-intestinal (feeding), and Skin/Physical

Management. Each "care elements" column of the Direct Nursing Services Clinical Criteria form is totaled and all column totals then added together to determine a final score. The final score equates to a tier level and available number of nursing hours based on that tier level.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

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	In Home Care Agency (ORS 443.305)
Agency	Direct Nursing Services Agency
Individual	Self-employed Registered Nurse or Licensed Practical Nurse
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:

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:

Direct Nursing Services Agency

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):*

agency certified under OAR 411-323 and endorsed to deliver DNS under OAR 411-380

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:

Individual

Provider Type:

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 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 case manager, along with the individual and his or her person centered planning team. These circumstances might include, but are not limited to, a significant change in the individual's support needs, an interest in making a significant career change, or a significant move that includes a change in providers.

The individual's employment team, including the ISP team and representatives from vocational rehabilitation services, must monitor the Discovery service to ensure the work is adequate and complete. If the service is incomplete, the individual and his or her ISP team can request additional Discovery related activities. In more serious cases where the service is inadequate, the individual and his or her ISP team can request a different Discovery provider. Discovery cannot be billed if the service or Discovery Profile are inadequate or incomplete as determined by the ISP team.

Personal care/assistance may be a component of Discovery/Career Exploration services, but may not comprise the entirety of the service.

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

Discovery/Career Exploration services must be completed within a three-month period with a three month extension for legitimate cause upon ODDS approval.

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

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):*

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:

ODHS

Frequency of Verification:

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

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 or CME;

(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 or CME 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:

ODDS

Frequency of Verification:

Upon initial enrollment as a service provider.

All employment service providers are subject to the same competency-based training, qualification, and credentialing requirements. This information is verified annually by the case managers 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.

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 ODHS to exceed the limit. Large gates such as automobile gates are excluded. Costs for paint and stain are excluded.

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

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

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

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:

CME

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 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 CME 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**
- ☐ **Remote/via Telehealth**

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 individuals disability, identified support needs, or specialized medical or behavior support needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

CME

Frequency of Verification:

Prior to authorization of service and payment

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. 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.)or EPSDT. This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid state plan services.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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:

CME

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 is a component of Small Group 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)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Small Group Employment Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Small Group Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Endorsement issued by the Department to a certified service provider that has met the qualification criteria outlined in OAR 411-345-0010 -411-345-0300 and OAR chapter 411, division 323.

Conditions that the Department may impose on an endorsement include but are not limited to: 1. Requiring additional staff or staff qualifications;
2. Requiring additional training;
For each specific geographic service area where services shall be delivered, a Medicaid
Performing Provider Number assigned by the Department as described in OAR chapter 411, division 370.

Staff Qualifications:

1. Be at least 18 years of age;
2. Have approval to work based on current Department policy and procedures for background checks in OAR 407-007-0200 to 407-007-

0370 and OAR 411-323-0050(6) of this rule;
3. Be literate and capable of understanding written and oral orders
4. Be able to communicate with individuals, physicians, 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:

ODHS

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

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

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**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

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:

CME

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:

☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Support Services Brokerages, and Community Developmental Disabilities Programs (CDDPs) or ODHS ODDS.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

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 ODHS 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, to include:

(8) “Subject individual (SI)” means an individual on whom BCU conducts a criminal records check and an abuse check, and from whom BCU may require fingerprints for the purpose of conducting a national criminal records check.

(a) An SI includes any of the following:

(A) An individual who is licensed, certified, registered, or otherwise regulated or authorized for payment by the Department or Authority and who provides care.

(B) An employee, contractor, temporary worker, or volunteer who provides care or has direct contact with clients, client information, or client funds within or on behalf of any entity or agency licensed, certified, registered, or otherwise regulated by the Department or Authority.

(C) Any individual who is paid directly or indirectly with public funds who has or will have direct contact with recipients of:

(i) Services within an adult foster home (defined in ORS 443.705); or

(ii) Services within a residential facility (defined in ORS 443.400).

(D) Any individual who works in a facility and provides care or has direct contact with clients, client information, or client funds secured by any residential care or assisted living facility through the services of a personnel services or staffing agency.

(E) Any individual who works in a facility and provides care, or has direct contact with clients, client information, or client funds secured by any nursing facility through the services of a personnel services or staffing agency.

(F) Except as excluded in section (8)(b)(C) and (D) of this rule, an individual who lives in a facility that is licensed, certified, registered, or otherwise regulated by the Department to provide care. The position of this SI includes but is not limited to resident manager, household member, or boarder.

(G) Any referral agent, and any employee of a referral agent of a long term care referral entity pursuant to OAR 411-058-0000 to 411-058-0100 who comes into direct contact with clients.

(H) For child foster homes licensed by the Department’s DD programs, or child foster or adoptive homes governed by OAR chapter 413 division 215:

(i) A foster parent or proctor foster parent;

(ii) An adoptive parent applicant or an approved adoptive parent;

(iii) A household member in an adoptive or foster home 18 years of age and over;

(iv) A household member in an adoptive or foster home under 18 years of age if there is reason to believe that the household member may pose a risk to children placed in the home; and

(v) A respite care provider.

(I) An individual with contact with clients, client information, or client funds, who is an employee, contractor, or volunteer for a child-caring agency governed by OAR chapter 413 division 215; an In-Home Safety and Reunification Services (ISRS) program; a Strengthening, Preserving and Reunifying Families (SPRF) provider; or a

system of care contractor providing child welfare services pursuant to ORS chapter 418.

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

(K) Pursuant to OAR 461-165-0180, a child care provider reimbursed through the Department's child care program, associated individuals, and other individuals in child care facilities that are exempt from certification or registration by the Office of Child Care of the Oregon Department of Education. Childcare provider SIs include:

(i) The childcare provider;

(ii) Employees of the childcare provider;

(iii) Any individual the childcare provider uses to supervise a child in the absence of the childcare provider;

(iv) Each individual 16 years of age or older who lives in the provider's home if child care is provided in the home;

(v) Each individual who visits the provider's home during the hours care is provided and may have unsupervised access to a child in care.

(L) An appointing authority, QED, or QEI associated with any entity or agency licensed, certified, registered, otherwise regulated by the Department, or subject to these rules.

(M) An individual providing on the job certified nursing assistant classes to staff within a long term care facility.

(N) A student enrolled in a Board of Nursing approved nursing assistant training program in which the instruction and training occurs solely in a nursing facility.

(O) Except for those excluded under section (8)(b)(B), a student or intern who provides care or has direct contact with clients, client information, or client funds within or on behalf of a QE.

(P) Any individual serving as an owner, operator, or manager of a room and board facility pursuant to OAR chapter 411, division 68.

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

(R) Any individual who is required to complete a background check pursuant to Department or Authority program rules or a contract with the Department or Authority, if the requirement is within the Department or Authority's statutory authority. Specific statutory authority or reference to these rules and the positions under the contract subject to a background check must be specified in the contract. The exceptions in section (8)(b) do not apply to these SIs.
(b) Scope of investigations. All screenings include information obtained from the Oregon State Police Law Enforcement Data System, but ODHS obtains from other sources and states the information necessary to complete the work. For example, ODHS 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. ODHS-authorized designees make final fitness determinations using a weighing test based on law enforcement data provided from the ODHS 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 ODHS has reason to believe that rescreening
is required.
(c) Process for ensuring mandatory investigations have been conducted according to policy. The ODHS Criminal

Records Unit (CRU) has developed standard forms and processes to initiate and conduct criminal background screening. The CRU approves all persons authorized by ODHS ("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.:

~ ODHS enrolls independent 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 ODHS worker enters information that license has been renewed. Licensing process involves sampling personnel files for evidence criminal background review and fitness determinations according to ODHS 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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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):

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service

providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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, except for parents of individuals less than 18 years of age and spouses of individuals, 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 may be paid when a conflict of interest is not present and the relative meets the qualifications, and is chosen by the individual. Oregon issued a policy transmittal on March 3, 2015 regarding conflict of interest. Exceptions to this policy may only be granted by ODDS. Requests for exception must be submitted to the Funding Review Committee. Requests should include a demonstration of effort to resolve any conflicts of interest through a thorough exploration of service setting options, a thorough exploration of available providers, and an inability to locate a qualified and willing designated representative.

Relatives may provide the services identified in the approved waiver for which they meet provider qualifications, based on the individual's assessed needs and identified in the approved ISP. Services provided, regardless of the provider, must be in accordance with any limits identified in the waiver and set forth in OARs
Relatives/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 case manager. 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 case manager. No providers, including
relatives/legal guardians, may sign off on their own time sheets or invoices showing the hours worked.

Consistent with information in Appendix C1 the following services may be provided by a relative:
Direct Nursing Services
Prevocational Services -Employment Path Services
Supported Employment - Individual Employment Support

○ **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. Any individual or agency including members of federally recognized tribes 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 providers as well as agency providers. Waiver Case Management services are provided under the a 1915(b)(4) authority with provider types limited to CDDPs, Brokerages, or ODDS.

Potential individual providers may approach any CME to request a review of their qualifications in order to become available to provide waiver services to waiver participants. Waiver participants may request that potential individual providers, chosen by themselves or their representative to provide waiver service, be vetted for qualifications.

Agencies desiring to provide waiver services can request an application from ODHS to provide waiver services. On average, it takes the ODHS DD Licensing Unit 30 days or less to issue a 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 as specified in Administrative Rules.

When a provider is certified by ODHS, the certification review process verifies training of a provider's employees. In services where individual providers are used, it is up to the individual or their employer agent to verify that their employee-provider has the training necessary to do their job tasks. Individual CMEs may assist those employers to verify. Any qualified individual or agency provider is available to be selected by a waiver participant to provide waiver services.

ODHS 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.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- ○ **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ○ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - ☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - ☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - ☐ **The HCBS must be identified in the individual's person-centered service plan; and**
  - ☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

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:
PM11: Number and percent of provider applicants who initially obtained the appropriate certification, licensure and/or endorsement prior to rendering waiver services. N: Number of provider applicants who initially obtained the appropriate certification, licensure and/or endorsement prior to rendering waiver services. D: Total number of provider applicants who rendered *waiver* services.

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

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

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

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:
PM12: Number and percent of providers who continually met the appropriate certification, licensure and/or endorsement while rendering waiver services. N: Number of providers who continually met the appropriate certification, licensure and/or endorsement while rendering waiver services. D: Total number of providers who rendered *waiver* services.

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

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

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

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 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:
PM13: Number and percent of non-licensed/non-certified providers who adhered to waiver requirements ongoing. N: Number of non-licensed/non-certified providers who adhered to waiver requirements ongoing. D: Total number of non-licensed/non-certified providers *who rendered waiver services.*

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

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

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

Data Source (Select one):
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: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

Performance Measure:
PM14: Number and percent of newly enrolled non-licensed/non-certified providers who adhered to waiver requirements. N: Number of newly enrolled non-licensed/non-certified providers who adhered to waiver requirements. D: Total number of newly enrolled non-licensed/non-certified providers *who rendered waiver services*.

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

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

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

Data 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: Biennially. Site and file reviews are conducted on an ongoing basis with reviews at each site every two years.

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:
PM15: Number and percent of all providers who met training requirements ongoing. N: Number of all providers who met training requirements ongoing. D: Total number of providers *who rendered waiver services.*

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

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

Data 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**

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

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

The frequency of data collection, aggregation and analysis is biennial with site and file reviews conducted on an ongoing basis with reviews at each site every two years. The sample universe will be comprised of waiver year 1 and 2 for the #0117, *2386* and #0375 waivers combined, to determine the statistically valid representative random sample size. The file review sample size used for all measures in Appendix D and two of the appendix G performance measures is based on a statistically valid representative random sample utilizing a 95% confidence level, 5% margin of error and 50% response distribution, as determined by the Raosoft sample size calculator found at http://www.raosoft.com/samplesize.html for the two-year cycle. This representative sample is proportioned across case management entities based on the percentage of the population served relative to the waiver population size. Half of the sample will be pulled for participants who were enrolled in waiver year one and the other half pulled for participants enrolled in waiver year two. Within the sample drawn each year of the biennial cycle, Oregon will over sample to account for multiple variable review, as well as to account for 'non-response' factors such as participants who are no longer enrolled in the waiver due to relocation out of state or death and participants whose length of enrollment within the review period is insufficient to produce results for the variables measured (e.g., service plan updated annually cannot be assessed for someone who is newly enrolled for less than 12 months).

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

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

The 0117, *2386* and 0375 waivers meet the following five CMS conditions:
1. Design of the waivers is the same or very similar;
2. This sameness or similarity is determined by comparing waivers on the approved waiver application appendices: a. Participant Services,
b. Participant Safeguards, and
c. Quality Management;
3. The quality management approach is the same or very similar across waivers, including:
a. Methodology for discovering information (e.g., data systems, sample selection),
b. Manner in which individual issues are remedied,
c. Process for identifying and analyzing patterns/trends, and
d. Majority of the performance indicators are the same;
4. The provider network is the same or very similar; and
5. Provider oversight is the same or very similar.

Data and reports gathered and created by ODHS staff during quality reviews are reviewed and analyzed on a continuous and ongoing basis by designated OHA staff, including the OHA liaison to ODHS, to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Upon completion of OHA' analysis and review of ODHS quality assurance data and reports, all relevant information from both agencies' reviews is compiled into a Quality Assurance overview report and is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC annually reviews the reports and document ODHS and OHA remediation efforts.

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

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

As designated OHA staff, the OHA liaison, and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Joint Policy and Operations Steering Committee outlined above, thus informing executive management of OHA and ODHS.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Individual remediation activities will require follow-up by the ODHS Quality Management Staff to determine that the corrective action was successfully completed by the field office, licensing or abuse investigation unit. The results of any remediation will be submitted to an inter-departmental workgroup for discussion, data collection and reporting. When individual and/or system-wide remediation activities are warranted based on discovery and analysis, the following time frames will be used to ensure these items are remediated in a timely manner. Because ODHS is monitoring the performance of its contractors (CMEs, and service providers)

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

ODHS timelines for remediation:

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

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

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

Timelines for systemic remediation:

Required system-wide changes: If changes require revision of administrative rules, the required changes will be completed within the time frames required by the administrative rule process, including Rule Advisory Committees (including stakeholder input), Administrative rule hearings and statutory filing time frames. If system-wide changes require waiver amendments, the process will be completed at the time of approval of the waiver amendment. This will include the 30 day public and 60 day tribal input period and 90 day approval process.

Follow-up to determine effectiveness of remediation activities will occur during the next discovery and review cycle using a comparison of compliance level pre- and post-remediation to determine the level of success with the remediation activity. After initial remediation is completed a follow-up will occur within

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

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

Waiver participants may receive home and community-based services in their own home, their family home, supported living setting or a residential service setting serving children or adults (24-hour group home, foster home, or host home).Participants may also receive waiver employment services, in a community setting, and/or a facility that meets the home and community-based regulations.

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

Case managers providing waivered case management services monitor for HCBS compliance in all settings where an individual receives waiver services, including where they live and employment services (if applicable).

While Oregon presumes that individual and privately-owned homes meet the requirements to be considered home and community based, ODDS has taken a multi-faceted approach to monitoring HCBS compliance in all settings where waiver participants receive home and community-based services.

In addition to the adoption of the over-arching HCBS OAR, specific language has been added to ODDS' Case Management Services OARs which require that the case manager must apply HCBS settings requirements to service planning and to monitor for compliance with the home and community-based services and settings rules. Case managers are required by OARs to conduct a monitoring visit to the home of every individual receiving home and community-based services at least annually. Case managers are specifically required to evaluate whether all service settings, including an individual's own private home, are compliant with HCBS OARs. Case managers also conduct monitoring activities in facility-based employment service settings. Furthermore, ODDS licensing also monitors credentials and provider compliance with HCBS at least every 2 years through the regular licensure and certification process that includes on-site review. Case managers have the authority to deny the authorization of services in settings where individuals or their representatives do not permit case managers to monitor the setting or service delivery for HCBS compliance.

If a case manager determines that developmental disabilities services are not being delivered in compliance with HCBS requirements or as agreed in the person-centered service plan, or if service needs have changed, a case manager must initiate at least one of the following actions: update the person-centered service plan; work with provider to identify service delivery shortcomings for remediation; provide or refer technical assistance to an agency provider or common law employer for a personal support worker; seek corrective action, if needed, by referring provider to ODDS Licensing for review or for administrative support; or meet with the executive director or board of directors of the provider.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☒ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☒ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☒ **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.**

☒ **Facilitates individual choice regarding services and supports, and who provides them.**

☒ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an**

intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

- ○ **No, the waiver does not include provider-owned or controlled settings.**
- ◉ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):
  - ☒ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**
  - ☒ **Each individual has privacy in their sleeping or living unit:**
    - ☒ **Units have entrance doors lockable by the individual.**
    - ☒ **Only appropriate staff have keys to unit entrance doors.**
    - ☒ **Individuals sharing units have a choice of roommates in that setting.**
    - ☒ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**
  - ☒ **Individuals have the freedom and support to control their own schedules and activities.**
  - ☒ **Individuals have access to food at any time.**
  - ☒ **Individuals are able to have visitors of their choosing at any time.**
  - ☒ **The setting is physically accessible to the individual.**
  - ☒ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

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

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) Oregon Administrative Rules (OAR Chapter 411, Division 415) and ISP manual, incorporated by reference in the Oregon Administrative Rules, establish standards for the development of service plans for individuals with intellectual and/or developmental disabilities. These plans are called Individual Support Plans (ISPs).

Through a process known as choice advising, all individuals and as applicable, their legal or designated representative, receive information on service options, service provider options, and HCBS setting options from their case manager prior to an initial ISP, at the renewal of an ISP, and as needed. Additionally, a case management entity (CME) is required to provide information and technical assistance to an individual, and as applicable the legal or designated representative of the individual, in order to make informed decisions. This may include, but is not limited to, information about support needs, settings, programs, and types of providers. Also, the case manager must
provide a description of the services available from the case management entity, including typical timelines for activities, required assessments, monitoring and other activities required for participation in a Medicaid program, and the planning process.

The standards for the development and implementation of an ISP require that an ISP is developed using a person-centered planning process in order to assist with establishing outcomes, planning for supports, and reviewing and redesigning support strategies. The case manager must facilitate active participation of the individual, and as applicable,their legal or designated representative throughout the planning process.

(b) The ISP is developed by the individual, and as applicable their legal or designated representative and the case manager. Others may be included as a part of the ISP team at the invitation of the individual and as applicable their legal or designated representative. Services included in an ISP may not begin until authorized by the signature of not only the case manager, but of the individual and as applicable the individual’s legal or designated representative, thus assuring their involvement in and agreement to its content. In instances where an individual has an inability to sign, and does not have a legal or designated representative, OAR requires that the individual be informed as completely as possible. In the case of an emergency, when a local, county or state emergency has been declared, the face to face requirement may be waived and signatures may be obtained by the use of e-signatures or email that meets privacy and security requirements as a method for the participant or legal guardian signing the ISP to indicate approval of the plan. Once the emergency declaration has ended, regular monitoring requirements will resume as specified in the person’s ISP, to assure the person’s health and welfare. This proposed request is specific to the ISP meeting only and does not waive any monitoring requirements currently in place.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency

or the operating agency (if applicable):

a) All individuals receiving services are required to have an authorized Oregon Individual Support Plan (ISP), using the standardized form SDS 4118, prior to the start of 1915(c) waiver and 1915(k) services, and renewed every 12 months.

The ISP is a holistic service plan that includes all components, strategies and protocols necessary for the individual to be healthy and safe. It includes the services to be received, Medicaid and non Medicaid. It also includes the scope amount, duration, frequency, and provider type. *The ISP is developed, reviewed and updated at least annually and must include a face-to-face ISP meeting with the individual and as applicable, their legal or designated representative. ISP meetings are held at least every 12 months, or more frequently as needed due to changes in support needs or as requested by the
individual and as applicable, their legal or designated representative. In the case of an emergency, when a local, county or state emergency has been declared, the face to face requirement may be waived and signatures may be obtained by the use of e-signatures or email that meets privacy and security requirements as a method for the participant or legal guardian signing the ISP to indicate approval of the plan. Once the emergency declaration has ended, regular monitoring requirements will resume as specified in the person's ISP, to assure the person's health and welfare. This proposed request is specific to the ISP meeting only and does not waive any monitoring requirements currently in place.

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

b) The ISP development incorporates the assessment process which includes the gathering of person centered information by the individual's case manager as well as a functional needs assessment, including risks, conducted by a state trained assessor or the person's case manager. Input into the person centered information comes from the person in services, and as applicable, their legal or designated representative and anyone else they invite to contribute. The individual's case manager captures the information on a standardized form recording the person's, and as applicable, their legal or designated representative's perspective about a wide range of areas in his or her life. The case manager notes what is important TO the individual through this process. The content of this document informs the development of the ISP and is used to ensure that individual preferences, goals and desired outcomes are addressed throughout.

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

- Communication
- ADL and IADL tasks
- Behavior
- Safety
- Medical

Included in the ISP is a Risk Management Plan with a description of what supports are available in the person's life to address each risk. This could include protocols designed to train staff and others on how to assist in managing the risk. Risks considered to be "high risks" are so identified, and prompt monthly monitoring. In the case of an emergency, when a local, county or state emergency has been declared, the face to face requirement may be waived and signatures may be obtained by the use of e-signatures or email that meets privacy and security requirements as a method for the participant or legal guardian signing the ISP to indicate approval of the plan. Once the emergency declaration has ended, regular monitoring requirements will resume as specified in the person's ISP, to assure the person's health and welfare. This proposed request is specific to the ISP meeting only and does not waive any monitoring requirements currently in place.

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

support-staff.
- The individual provides informed consent for this type of assessment.

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

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

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

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

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

g) Case managers are responsible for monitoring the individual's services to assure that the ISP is implemented and that waiver and other services are coordinated, provided and meet the individual's service and support needs as identified in the functional needs assessment and ISP. The ISP document includes a field for identifying who is

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

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

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☐ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☐ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☐ **A specific and individualized assessed need for the modification.**
- ☐ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☐ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☐ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☐ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☐ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☐ **Informed consent of the individual.**
- ☐ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The ISP is required to be developed based on an assessment process which includes the gathering of Person Centered Information by the individual's case manager as well as the functional needs assessment, including risks, conducted by a state trained assessor or case manager.

The functional needs assessment is a standardized assessment constructed to identify risks related to aspiration, dehydration, choking, constipation, seizures, and other health risks. Potential risks to personal safety such as the ability to regulate water temperature, evacuate for a fire, vehicle safety and others are assessed. The functional needs assessment prompts
evaluation of the risk for abuse, for mental health concerns, and challenging behaviors.

When an individual is identified as having three or more high risks, the ISP is required to include that the case manager will provide at least monthly monitoring to assure the individual's ongoing health and safety. A serious risk is one that, without support, would likely result in hospitalization, institutionalization, legal action, or place the person or others in imminent harm.

The identification of a risk triggers a discussion of services available to address the risk. For many risks, this means the development of protocols or support documents for care givers to follow in order to prevent, minimize and respond to the presence of risks. 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. A Financial Plan is required for every individual residing in a setting licensed by the Department when the individual 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. A BSP outlines strategies to ensure the safety of the individual and others through positive supports when the individual engages in challenging behaviors, and must be written in accordance with OARs specific to behavior supports found in OAR chapter 411, division 304.

The ISP form has a section known as the Risk Management Plan. For each known risk, the strategy to mitigate it is identified in the Risk Management Plan section of the ISP. Each strategy must be developed with the individual's preferences for supports in mind and cannot be included if not agreed to by the individual or their legal or designated representative. An individual may choose to leave a risk unaddressed after being informed of potential consequences and available supports. This information is captured in the ISP. The risk management plan also includes prompts to address emergency
preparedness (in the event of natural disasters, power outages, etc.), abuse prevention, and emergency contacts. The ISP has a section for back up plans in the event a primary support is unavailable. These are specific to the individual and based on the unique circumstances and preference of the individual or the individual's legal or designated representative. The backup plan may rely on temporary natural support from family or community resources, or alternate individual or agency providers.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The waiver service of case management operates under a concurrent 1915(b)4 waiver of free choice of provider. However, OAR Chapter 411 Division 415 does assure that the individual receiving services, or as applicable the legal or designated representative of the individual, may request a new case manager within the same case management entity. Oregon Revised Statute 427.154 allows Brokerages to provide case management services only to adults residing in their own home or the home of the adult's family. Therefore, individuals residing in a 24 hour residential setting will not be offered the choice of case management services through a brokerage.

Providers of other waiver services are made known to the individual through the choice advising process. Through it, all individuals and their legal or designated representatives new to service and, minimally, prior to an initial ISP or a renewal of an ISP get information on service options, provider options, and HCB setting options from their case manager OAR Chapter 411 Division 415. Additionally, a case management entity is required to provide information and technical assistance to an individual, and as applicable the legal or designated representative of the individual, in order to make informed decisions. This may include, but is not limited to, information about support needs, settings, programs, and types of providers.
Independent providers of Individual Supported Employment – Job Coaching are encouraged to make themselves available to waiver participants through a publicly available registry of qualified individual providers.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

OHA is the Single State Medicaid/CHIP agency (SSMA) responsible for the administration of programs funded by Medicaid and CHIP in Oregon. ODHS 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.
ODHS is responsible for certain Medicaid/CHIP services as an Organized Health Care Delivery System, providing program administration and as a direct service provider, as outlined in the agreement for services, including but not limited to:
1. Waiver Case Management (WCM) for all applicable programs administered by ODHS;
2. Home and Community-Based Services for programs operated by ODHS; and
3. Other services provided in accordance with the Medicaid/CHIP state plan such as personal care services, contracted nursing services, and rehabilitative services, to the extent such services are administered by ODHS."
ODHS staff compile, review and analyze performance data through a variety of file reviews and data reports.
1. ODHS generates two statistically valid statewide samples of all individuals receiving Medicaid services through the waiver just prior to the beginning of each new two year review cycle. The sampling methodology is based on a random sample of adult's files case managed by CDDPs and Brokerages using a 95/5/50 method. The reviews occur over the course of a two-year cycle. The cycle begins in July and ends in June two years later. All CMEs are visited during this two year cycle.
2. ODHS conducts comprehensive reviews of each CME's case management services, including service plans, once every two years.
3. Each CME knows the month and year which their review will occur. However, the individuals pulled from the sample are not shared with the CME until approximately 1 month prior to the review.
ODDS' QA unit will conduct an onsite visit at each CME and each file audited includes a thorough review of the individual's:
a. Service Plan to ensure:
i. The ISP is based on an assessment of individual need
ii. Health and safety risks are addressed
iii. The plan reflects individual choice, including but not limited to choice of services and providers
iv. Is implemented appropriately (finalized and signed; completed within 12 months of the previous plan)
b. Monitoring of services, including assessment that current plan continues to meet individual's needs, including health and safety risks; that the person is satisfied with their services; and whether or not changes to the current plan needs to be made.
c. Health and Welfare, including notification of abuse reporting process, and follow up on any serious events
d. Complaints
e. Qualified Case Management Encounters
f. Home and Community Based Service rule compliance.
4. Remediation: A draft of the final report is submitted to the CME within 30 days of the conclusion of the onsite field review. The CME has up to 45 days to contest findings and to submit a corrective action plan. At the conclusion of the 45 days, a final report is issued and the CME has up to 60 days to correct identified deficiencies.
The CMEs are responsible to provide evidence of correction to ODDS. Once it is determined the CME has addressed all required actions identified in the corrective action plan, the CME is informed there will be no additional follow up and the formal review process is closed.
5. Follow up—If ODDS has concerns about any aspect of the CMEs ability to provide compliant services, a follow up review may be scheduled. These reviews may target specific aspects of the CME's case management activities or a full review of all CME services may be conducted.
6. Collaboration with Medicaid agency (OHA): All final reports are sent to OHA for review. While they do not authorize the final report, they have the opportunity to follow up on the results of each review conducted.

Appendix D performance measures include both a ODHS and OHA review of the ISP to ensure the ISPs are developed and implemented in accordance with the waiver.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, 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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

As required by OAR Chapter 411 Division 415, every individual who has an ISP must have a case management contact no less than once every three months. Individuals with three or more high risks as identified in the functional needs assessment, or if determined to be necessary by the case manager, must have
monthly case management contact. At least one case management contact per year must be face to face. If an individual or legal representative agrees, other case management contact may be made by telephone or by other interactive methods, depending upon the individual's preference. The purpose of the case management contact is:
• To assure known health and safety risks are adequately addressed;
• To assure that the support needs of an individual have not significantly changed; and
• To assure that an individual and designated representative is satisfied with the current supports.
In addition, as required by OAR a case manager must conduct service monitoring activities at a frequency established in the ISP, based on the individual's circumstances, but at a minimum of once per year, that includes an assessment of the following:
• Are services being provided as described in the ISP and do the services result in the achievement of the identified action plans?
• Are the personal, civil, and legal rights of the individual protected in accordance with Oregon Administrative Rules?
• Are the personal desires of the individual, and as applicable the legal or designated representative or family of the individual, addressed?
• Do the services authorized in the ISP continue to meet the assessed needs of the individual and what is important to, and for, the individual?
• Do identified desired outcomes and associated goals and action plans remain relevant and are the goals supported and being met?
• Are technological and adaptive equipment and environmental modifications being maintained and used as intended?
• Have changing needs or availability of other resources altered the need for continued use of Department funds to purchase supports?
• Are the services delivered in a setting that is in compliance with HCBS setting rules?

This assessment may be made based on direct observation of the individual, interviews with the individual and others who know the individual and the circumstances, including care givers. Documentation submitted by care givers in support of reimbursement claims may serve as the basis for a service review, as can documentation
reporting unusual incidents. OAR Chapter 411 Division 415 requires that a case manager visits each licensed residential setting at least quarterly, other provider owned and controlled sites must be visited at least annually, to assure they remain safe and adequate for the delivery of services.

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

A case manager and the CME are responsible for ensuring the appropriate follow-up to monitoring of services. If the case manager determines that developmental disabilities services are not being delivered as agreed in the ISP for an individual, or that the service needs of an individual have changed since the last review, the case manager must update the ISP of the individual and/or provide or refer technical assistance to an agency provider or to the person directing the implementation of the plan.

ODHS conducts comprehensive reviews of each CME's case management services, including service plans, once every two years and will conduct an onsite visit at each CME. Each file audited includes a thorough review of the individual's: a. Service Plan to ensure: i. The plan is based on an assessment of individual need ii. Health and safety risks are addressed iii. The plan reflects individual choice, including but not limited to choice of services and providers iv. Is implemented appropriately (finalized and signed; completed within 12 months of the previous plan) b. Monitoring of services, including assessment that current plan continues to meet individual's needs, including health and safety risks; that the person is satisfied with their services; and whether or not changes to the current plan needs to be made. c. Health and Welfare, including notification of abuse reporting process, and follow up on any serious events d. Complaints e. Qualified Case Management Encounters f. Home and Community Based Service rule compliance.

A provider of case management must notify the Department, per OAR 411-415-0090 (5), when a provider demonstrates substantial failure to comply with any applicable licensing, certification, or endorsement rules for Department-funded programs, when an provider may meet conditions that would cause the provider's ability to deliver services to be withdrawn, when there is a serious and current threat endangering the health, safety, or welfare of individuals in a program for which an immediate action by the Department is required, and when an individual receiving services dies.

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

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

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the**

plan development function from the direct service provider functions.

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

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

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

		A random sample of the combined populations of waivers 0117, *2386* and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: biennially	

Data Aggregation and Analysis:

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

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

Performance Measure:
PM17: Number and percent of waiver participants whose service plan included services and supports that addressed assessed needs. N: Number of waiver participants whose service plan included services and supports that addressed 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 = A random sample of the combined populations of waivers 0117, *2386* and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:
PM18: Number and percent of waiver participants whose service plan addressed personal goals and preferences. N: Number of waiver participants whose service plan addressed personal goals and preferences. D: Total number of waiver participants reviewed.

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

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

collection/generation *(check each that applies):*	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = A random sample of the combined populations of waivers 0117, *2386* and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: biennially	

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

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

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

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

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/5%/50%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: biennially	

Data Aggregation and Analysis:

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

c. ***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:
PM19: Number and percent of waiver participants whose service plan was revised, as needed to address changing needs. N: Number of waiver participants whose service plan was revised, as needed to address changing 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 = A random sample of the combined populations of waivers 0117, *2386* and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:
PM20: Number and percent of waiver participants whose service plan was updated/revised at least every 12 months. N: Number of waiver participants whose service plan was updated/revised at least every 12 months. 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 = A random sample of the combined populations of waivers 0117, *2386* and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: biennially	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**

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

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

Performance Measures

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

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

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

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

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

☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = A random sample of the combined populations of waivers 0117, *2386* and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

Data Aggregation and Analysis:

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

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

Performance Measure:
PM22: Number and percent of waiver participants whose services were delivered in the type specified in the service plan. N: Number of waiver participants whose services were delivered in the type specified in the service plan. D: Total number of waiver participants reviewed.

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

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

		A random sample of the combined populations of waivers 0117, *2386*, and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: biennially	

Data Aggregation and Analysis:

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

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = A random sample of the combined populations of waivers 0117, *2386*, and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:
PM 24: Number and percent of waiver participants whose services were delivered in the duration specified in the service plan. N: Number of waiver participants whose services were delivered in the duration specified in the service plan. D: Total number of waiver participants reviewed.

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

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

collection/generation *(check each that applies):*	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = A random sample of the combined populations of waivers 0117, *2386*, and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

Data Aggregation and Analysis:

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

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

Performance Measure:
PM 25: Number and percent of waiver participants whose services were delivered in the scope specified in the service plan. N: Number of waiver participants whose services were delivered in the scope specified in the service plan. D: Total number of waiver participants reviewed.

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

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

		A random sample of the combined populations of waivers 0117, *2386*, and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

Data Aggregation and Analysis:

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

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

e. ***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:
PM26: Number and percent of waiver participants who were offered choice among providers. N: Number of waiver participants who were 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 =

		A random sample of the combined populations of waivers 0117, *2386*, and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: biennially	

Data Aggregation and Analysis:

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

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

Performance Measure:
PM27: Number and percent of waiver participants who were offered the choice of waiver services. N: Number of waiver participants who were offered the choice of 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 = A random sample of the combined populations of waivers 0117, *2386*, and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☒ **Other** Specify: biennially	

Data Aggregation and Analysis:

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

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

The frequency of data collection, aggregation and analysis is biennial with site and file reviews conducted on an ongoing basis with reviews at each site every two years. The sample universe will be comprised of waiver year 1 and 2 for the #0117, *#2386*, and #0375 waivers combined, to determine the statistically valid representative random sample size. The file review sample size used for all measures in Appendix D and two of the appendix G performance measures is based on a statistically valid representative random sample utilizing a 95% confidence level, 5% margin of error and 50% response distribution, as determined by the Raosoft sample size calculator found at http://www.raosoft.com/samplesize.html for the two-year cycle. This representative sample is proportioned across case management entities based on the percentage of the population served relative to the waiver population size. Half of the sample will be pulled for participants who were enrolled in waiver year one and the other half pulled for participants enrolled in waiver year two. Within the sample drawn each year of the biennial cycle, Oregon will over sample to account for multiple variable review, as well as to account for 'non-response' factors such as participants who are no longer enrolled in the waiver due to relocation out of state or death and participants whose length of enrollment within the review period is insufficient to produce results for the variables measured (e.g., service plan updated annually cannot be assessed for someone who is newly enrolled for less than 12 months).

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

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

The 0117, *2386*, and 0375 waivers meet the following five CMS conditions:
1. Design of the waivers is the same or very similar;
2. This sameness or similarity is determined by comparing waivers on the approved waiver application appendices: a. Participant Services,
b. Participant Safeguards, and
c. Quality Management;
3. The quality management approach is the same or very similar across waivers, including:
a. Methodology for discovering information (e.g., data systems, sample selection),
b. Manner in which individual issues are remedied,
c. Process for identifying and analyzing patterns/trends, and
d. Majority of the performance indicators are the same;
4. The provider network is the same or very similar; and
5. Provider oversight is the same or very similar.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Individual remediation activities will require follow-up by the ODHS Quality Management
Staff to determine that the corrective action was successfully completed by the field office, licensing or

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

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	ODHS-Site/file reviews conducted ongoing with on-site reviews every two years OHA-reviews ODHS through regularly scheduled MOCSC meetings to identify trends that may require statewide QIS changes.

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

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.
ODHS provides opportunities for participants and/or their legal or designated representative to exercise Employer Authority in Supported Employment - Individual Employment Support (Job Coaching).

Individuals or their legal or designated representative can 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 case manager will discuss various waiver services options with every eligible individual or legal or designated representative who chooses home and community-based services.

(c) Entities involved in supporting participant direction and supports provided.
1) Information and assistance in support of participant direction:
~ Case managers 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 ODHS. Participants select their own providers.

~ Supports to the employer include, but are not limited to: education about employer responsibilities; orientation to basic wage and hour issues; use of common employer-related tools such as job descriptions; and fiscal intermediary/employer agent services.
~ Most CMEs have developed an orientation for participants that describes roles and responsibilities of participants, CMEs and Providers.
~ The case manager 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 every 12 months. Case Managers are expected to identify and monitor more closely if the situation warrants, for example if the individual's health is particularly fragile, if there are provider issues, mental health concerns or protective service issues. The participant has the right to terminate the employment relationship with the provider at any time, for any reason.
~ Case managers 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:
ODHS contracts with outside Fiscal Intermediary (FI)/Employer Agent (EA) to perform the FI/EA duties. The CME is jointly responsible with the FI/EA for assuring financial management services are provided appropriately.
The FI/EA issues payment to the qualified provider and handles employer-related financial requirements on behalf of the participant-employer. The participant-employer signs off on time sheets and invoices verifying the number of hours their employee worked, up to the maximum hours authorized by the Individual Support Plan. Case managers, by direct or telephone contact with the participant, may also verify services provided.
Case managers may assist the participant with creating job descriptions and service agreements based on the Individual Support Plan.
There are currently no adults self-directing services in this waiver. The Oregon ISP has a section that addresses Back-up plans and must be completed for all individuals. Agency based services would be available to individuals no longer self-directing services and the case manager would initiate the established back up plan along with monitoring activities ensures service continuity and participant health and welfare during transitions.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

◉ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

○ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Individuals residing in a licensed or certified 24 hour residential setting.
Host Home
Non-Relative Children's Developmental Disability Foster Care:
(a) The capacity of a certified child foster home includes all children living in the home and may not exceed the following, except as described in section 411-346-0180(3)(c):
(A) A total of four children when one certified adult lives in the child foster home.
(B) A total of seven children when two certified adults live in the child foster home.
(b) The capacity of a child foster home is limited to two children less than three years of age.
(c) A foster provider certified prior to July 1, 2007 with a capacity greater than the numbers listed in section 411-643-0180(3)(a)must meet the standard through attrition as children move out of the child foster home.
Children’s and Adult Group Care Home
The vast majority of residential settings have a capacity of 5 or fewer residents who are MR/DD A few settings range from 6 to 20 residents
Non-Relative Adult Foster Care
Five or fewer individuals with DD/IDD.

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 or designated representative expressing interest in directing Supported Employment - Individual Employment Support (Job Coaching) are informed of their service options when they apply for home and community based services. The participant or legal or designated representative is assisted by their case manager 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 CME to individuals prior to participants and/or their legal or designated representative directing services. This information includes requirements for entry, conditions for exit; a description of processes involved in receiving services, including person-centered planning, evaluation, and how to raise and resolve concerns about services; and an explanation of individual rights to select and direct providers of services authorized through the individual's service plan from among qualified providers.
CMEs are required to inform individuals, their legal or designated representatives and families of their grievance and appeal rights. This information is provided both orally and in writing to participants by their case manager. 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 CME 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. A case manager, through monitoring contacts solicits information from and gives feedback to an individual to help determine if the designated representative is acting in the individual's best interest.

Oregon issued a policy transmittal on March 3, 2015 which clearly outlines the guidelines for appointing a non-legal representative as well as forms that can be utilized by the designated representative and the person appointing them.

Exceptions to this policy may only be granted by ODDS. Requests for exception must be submitted to the Funding Review Committee. Requests should include a demonstration of effort to resolve any conflicts of interest through a thorough exploration of service setting options, a thorough exploration of available providers, and an inability to locate a qualified and willing designated representative.

Based upon Oregon Administrative Rules, CMEs 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 CME or Department, as applicable, and the CME 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
Supported Employment - Individual Employment Support	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

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

The waiver service entitled:

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

Provide the following information

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

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

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 as documented in a contract between ODHS and the FMS.

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.

ODHS monitors and assesses the performance of FMS entities in the following ways:

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

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Waiver Case Management	☒
Discovery/Career Exploration Services	☐
Direct Nursing	☐
Family Training - Conferences and Workshops	☐
Employment Path Services	☐
Supported Employment - Small Group Employment Support	☐
Specialized Medical Supplies	☐
Supported Employment - Individual Employment Support	☐
Environmental Safety Modifications	☐
Vehicle Modifications	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Participants who voluntarily terminate their self-directed services are counseled by their case manager about other service options. The Oregon ISP has a section that addresses back-up plans in the event that primary support is not available and must be completed for all individuals. Initiating the established back up plan along with monitoring activities ensures service continuity and participant health and welfare during transitions.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

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 CME; intervention include 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, mileage logs, or other required documents submitted for payment that results in repeated coaching from the Department or CME;
(D) Complaints to Medicaid Fraud involving the individual or the individual's representative; or
(E) Documented observation by the CME of services not being delivered as identified in the individual's Individual Support Plan.

When employer authority is removed, the identified support needs can be met using services available through this waiver from provider types that do not have an employment relationship with the individual – contractors, certified provider organizations or a general business. Specific providers of these types may be selected from those available by the individual or the individual's legal representative. Participant direction of these providers will be encouraged and allowed to the greatest extent possible. The individual's case manager will revise the previously authorized ISP to assure all support needs formerly met by the employee will be met by the new provider type.

If the individual chooses not to utilize the alternate provider types or alternate provider types are unavailable, the individual or the individual's legal representative will be advised of options for meeting identified needs through other home and community based services that are not available through this waiver. Individual's will be informed of the opportunity to request a Fair Hearing in accordance with the procedures specified in Appendix F-1

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	2000	
Year 2	2500	
Year 3	3000	
Year 4	3500	
Year 5	4000	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

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

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

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☒ **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.

ODHS has implemented procedures to inform individuals of their right to request a Fair Hearing upon application, and at the Individual Support Plan (ISP) meeting and upon request, by providing the FACT sheet (SDS 0948). *The case manager reviews the Notification of Rights with the individual or their guardian in their preferred format and document in a progress note.

The Department has implemented rules that require anytime an individual's benefits/services are denied, terminated, suspended or reduced they will be given timely, written notice and advised of their fair hearing rights by receiving a Notification of Planned Action (form SDS 0947). The Notification of Planned Action includes the reason for the decision or action, the statute and rules relied upon in making the decision, the records used to make the decision, the manner in which to request a hearing and how to request continuing services as well as the individual's right to due process via a fair hearing. Decision notices must be mailed at least 10 days prior to the action being taken, per Oregon Administrative Rule Chapter 461 Division 175. Individuals are afforded the opportunity to request a Fair Hearing in all instances when they are not provided the choice of HCBS as an alternative to institutional care.

Form SDS0422DD, the Office of Developmental Disability Services Administrative Hearing Request, included with all notices of planned actions, contains the question, "Do you want your services to stay the same (not reduced or stopped) while you wait for a hearing?". From there, they are referred to another part of the form that explains continuing services. If the individual misses the deadline for requesting continuing services a request can still be made and ODHS will determine if there is good cause for the late request for continued services. The individual records their preference on the hearing referral form (SDS 0443 DD) with the understanding that they may be liable for the costs of services received if the hearing decision is unfavorable to them.

Upon receipt of a Notification of Planned Action or if the case management entity failed to make a timely decision, the individual or their legal or designated representative may request a Fair Hearing. The request for a Fair Hearing is made by completing the Administrative Hearing Request form (SDS 0443DD) and submitting the form to the case management entity or the Department. If a request for a hearing is made orally by the individual or their representative, the 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. ODDS also has a website that informs individuals and families about the Administrative Hearings process,
includes a link to the request form and allows people to contact ODDS directly.

ODHS 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 ODHS 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 ODHS lay representatives and OAH. The Department is responsible for referring the hearing request to the ODHS lay representative, who reviews both the Notification of Planned Action (SDS 0947) that was sent to the individual and the request for the hearing (SDS 0443DD). The ODHS lay representatives are centralized and not part of any local office that determines benefits, services, or eligibility. Hearings are held by the Office of Administrative Hearings, which is independent from the Oregon Department of Human Services.

The ODHS lay representative facilitates an informal phone conference between the individual or their representative and the Department. The informal conference is an opportunity to provide the individual or their representative the opportunity to question the planned action and to present additional information if applicable.

For all hearings that are held before an Administrative Law Judge, the individual or their representative is sent a Notice of Hearing by the OAH with a date and time for a hearing. All hearings are held over the phone unless the individual or their representative requests to have the hearing in person. The outcome of the hearing results in a Proposed Order, Proposed or Final Order, or Final Order that is issued by the OAH. If a Proposed Order is issued, the Department issues a Final Order after 21 days if no written exceptions are filed.

If the individual or their representative disagrees with the Final Order the individual or their representative may appeal the final order by filing a petition in the Oregon Court of Appeals.

The Department maintains a database and tracks each phase of the hearings and the outcome(s) for each hearing. Additionally, the Department maintains a file of all records relied upon during the hearing. A copy of the hearing request and Final Order is sent to the case management entity upon completion of the hearing.

All applicants and recipients of Department programs that require written materials in alternative formats or in their native language are accommodated as well as individuals that require translation or interpreter services. The assistance relies on professional translators/interpreters or services such as Language Lines, ASL, TTY. Other forms of augmentative and/or alternative communication are also options for these individuals.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

• **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.

Do not complete this item.

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**

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

Oregon Department of Human Services.

• **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. Making a complaint or filing a grievance is not a pre-requisite or substitute for a Fair Hearing.

Complaints may be filed with several entities including:
(A) Complaints regarding dissatisfaction with the services of a provider organization may be filed directly with the provider organization, with the individual's CME, or with the Department.
(B) Complaints regarding dissatisfaction with the services of a CME may be filed directly with the CME, or with the Department.
(C) Complaints regarding dissatisfaction with the Department must be filed with the Department.

A complaint is an expression of dissatisfaction with services or service providers. The CME is required to inform individuals or the individual's representatives of their right to file a complaint upon start of services, 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 CME and ODHS.

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ODHS/ODDS requires the reporting of abuse and certain critical incidents (serious incidents), defined in OAR 411-317-0000 for adults and children with developmental disabilities and addressed in OAR Chapter 411, Divisions 320, 323, 340, 346, 360, 375, and Chapter 407, Division 045. This reporting is done across all service settings as events occur. Reporting may occur by phone, in-person, email, writing, or verbally. Any employee of a case management entity or provider organization is required to report incidents of abuse when the employee comes in contact with and has reasonable cause to believe that an individual has suffered abuse or that any person with whom the employee comes in contact has abused the individual. Personal support workers must also report suspicion of abuse. This notification must occur immediately, no longer than one business day from the incident.

Notification of mandatory reporting status must be made at least annually to all case management entity and provider organization employees on forms provided by DHS. All employees must be provided with a DHS-produced card regarding abuse reporting status and abuse reporting. Any allegation of abuse must immediately be reported to the local CDDP, to a local law enforcement agency, or to the Department. Reports may also need to be made to Law Enforcement or Child Welfare based upon the nature of the allegation and investigative authority.
In the case of a serious illness, serious injury, or death of an individual, a provider must immediately, but not later than one business day, notify: the individual's legal or designated representative, parent or next of kin, if known, and any person identified by the individual to be contacted under these circumstances; the individual's case management entity; and any other agency responsible for, or delivering services to, the individual.

A provider must immediately, but not later than one business day, notify the individual’s case management entity of the use of an emergency physical restraint, an approved physical restraint when the individual is injured during its use or when the individual is missing.
ODHS maintains a secure, web-based incident management system for identification and tracking of abuse allegations and serious incidents. Assigned staff at case management entities enter serious incidents, described below and defined by OARs listed above, into the incident management system. Specially trained staff at a CDDP enter allegations of abuse. Utilization of the ODHS incident management system is mandatory. Case management entities enter information about the serious incident into the incident management database within seven calendar days of receipt of the report. Reports of abuse must be entered into the incident management system immediately. Instances of abuse of an adult are defined in Oregon Revised Statutes as:
(a) Abandonment,
(b) Any physical injury to an adult caused by other than accidental means, or that appears to be at variance with the explanation given of the injury.
(c) Willful infliction of physical pain or injury upon an adult.
(d) Sexual abuse of an adult.
(e) Neglect.
(f) Verbal abuse
(g) Financial exploitation
(h) Involuntary seclusion for the convenience of the caregiver or to discipline the person.
(i) A wrongful use of a physical or chemical restraint
(j) An act that constitutes a crime under ORS 163.375, 163.405, 163.411, 163.415, 163.425, 163.427, 163.465 or 163.467.
(k) Any death of an adult caused by other than accidental or natural means

Senate Bill (SB) 243 (2017) increases the oversight of children and young adults in out-of-home settings and ensures the continued safety and well-being of children and young adults in these settings. The definition of abuse in SB 243 (2017) has been expanded to include new types of abuse that apply to a “child in care.” Children and young adults (under age 21 (individuals aged 18 to 21 in this waiver)) placed in the following out-of-home settings meet the definition of a “child in care” under SB 243 (2017): ODDS-certified children’s foster homes; ODDS-licensed children’s residential settings; ODHS Child Welfare certified foster homes; Child Caring Agencies as defined in ORS 418.205. The new types of abuse include, but are not limited to, the following: physical injury, neglect, abandonment, willful infliction of pain, sexual abuse, verbal abuse, financial exploitation, involuntary seclusion, and wrongful use of a physical or chemical restraint. In addition to the mandatory abuse reporting requirements under ORS419B.005 to 419B.015, employees, alternate caregivers, and volunteers of ODDS-licensed children's residential settings must immediately report to ODHS Child Welfare suspected abuse of a child in care as defined by SB 243 (2017).

A serious Incidents is:
(a) An act of physical aggression by an individual resulting in injury.

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

Provider organizations are required to complete a written incident report for any:
(a) serious incident.
(b) allegation of abuse.
(c) Use of a safeguarding intervention.
(d) Use of an emergency crisis strategy.
(f) Fire requiring the services of a fire department.
(g) Medication error.

Copies of all written incident reports involving abuse must be sent by the Brokerage to CDDP staff within 5 days. Written incident reports must be sent to the individual's case management entity within five working days of the incident. A written incident must be prepared at the time of the incident and placed in the individual's record. The report must include:
~ Conditions prior to or leading to the incident;
~ A description of the incident;
~ Staff response at the time; and
~ Administrative review and follow-up to be taken to prevent recurrence of the unusual incident.

CDDP Abuse Investigators are responsible for determining whether or not an allegation of abuse meets the threshold for an Abuse Investigation. 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 Training, Information and Safety (OTIS).

Upon entry of any allegation of abuse into the incident management system, a decision to proceed with an abuse investigation is required. When the CDDP has initiated an abuse investigation, the CDDP must ensure that either the appropriate CDDP staff or the brokerage also immediately notify the individual's legal guardian. The parent, next of kin or other significant person may also be notified unless the individual requests the parent, next of kin or other significant person not be notified about the abuse investigation or protective services, or unless notification has been specifically prohibited by law. If necessary, due to findings of subsequent review or investigation, the CDDP can update the incident management system to change this decision. CDDPs often receive reports that must also be referred to other agencies for investigation or other resolution: - ODHS, Child Welfare investigates child abuse or may delegate investigation responsibility to OTIS. - If a crime occurs, law enforcement is involved. - OTIS investigates allegations of abuse involving individuals residing in host homes and residential group care homes operated by the ODDS Stabilization and Crisis Unit (SACU). 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 incident management system notes a referral to OTIS that an abuse investigation is required, as well as documents referral to other appropriate investigative agencies. OTIS accesses this information directly from the incident management system. The incident management system 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. Abuse Investigators are required to be completed within 55 days of the date the incident was assigned for investigation unless an extension is approved by OTIS. Participation of other investigative agencies, e.g. State and/or Law Enforcement, may cause a delay in completion of those investigations.

Non-abuse related serious incidents must be monitored and must be entered into the incident management system no more than seven calendar days after the case management entity receives notification of the incident. Case Managers or case management entity management, separately or as a team, clarify the nature of these serious incidents and take any steps necessary to address causes and prevent recurrence. It is not necessary to document the follow up in the web-based incident management system on initial entry; CMEs update the record as the review process develops and concludes. A

serious incident record in the incident management system must be closed within 30 days of entering the serious incident in the incident management system.

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.

At a minimum upon entry to services and every 12 months thereafter, or as requested, each individual participant and/or their family or their legal representative, as appropriate, receives written information of their rights as a client, including their right to safe services, how to report complaints, and how and where to report suspected abuse or neglect. This is confirmed by the acknowledgement of Notice of Rights form 948 which is included in each individual's record maintained by the CME. Information provided also includes the statewide phone number for reporting abuse.
Additionally case managers also encourage participants, through phone and direct contact, and monitoring, to communicate concerns, complaints or reports of abuse at any time. This information comes from the case manager or from service providers or both. Individuals, their families, or legal representatives are informed that their case manager and their service providers are mandatory reporters of suspected abuse and neglect.
ODHS maintains extensive online and printed materials on how to report abuse and neglect of children and adults.
ODHS, Office of Training, Information and Safety (OTIS) provides 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.
All trainings and presentations presented by OTIS, include the statewide toll free abuse reporting number and information for contacting the local county as an alternative way to initiate a report of abuse or neglect.
Providers (Direct Support Professionals, DSPs) in 24-hour residential programs and settings for children and adults with intellectual or developmental disabilities are required to complete core competency training which includes local training titled, "Rights: Mandatory Abuse Reporting" and an online training module titled, "Rights: Preventing Abuse, Neglect, and Exploitation".
Department produced wallet cards that contain mandatory abuse reporting status and abuse reporting requirements are provided to all agency staff, providers, volunteers and contractors which are providing I/DD services in community based-settings. Providers are required to report all allegations of abuse and neglect.

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 written incident reports on non-abuse related serious incidents to case managers within five business days of the incident. CDDPs are required to enter statutorily defined instances of abuse into the incident management system within 1 calendar day of notification and follow the processes described in Appendix G-1-b. For other serious incidents that may not constitute abuse, CMEs are required to enter the incident into the incident management system within 7 calendar days upon notification. CMEs receive, review, and follow up reports of incidents involving individuals with developmental disabilities per Oregon Administrative Rule requirements.

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

CDDPs are required to complete their County Review process and Abuse Investigations within 55 calendar days from date of entry of incident into the incident management system (delays by law enforcement or other investigative agency could extend this timeline). Non-abuse related serious incidents must be reviewed and responded to within 30 days. CME incident management teams convene at least quarterly to identify trends, develop local and system-wide responses, and identify preventive actions to address system deficiencies or emerging concerns that could potentially harm individuals served. The CME must submit findings to the Department quarterly on a format determined by the Department.

Abuse related investigations are generally conducted by CDDP abuse investigators. However, OTIS 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 host home or residential group care homes operated by the ODDS Stabilization and Crisis Unit (SACU). Law Enforcement Agencies (LEA) or local District Attorneys (DA) are responsible for investigating criminal allegations. These entities do not have access to the incident management system. Cross reporting between Child Welfare and LEA is covered in Oregon Administrative Rule 413-015-0300 to 0310 and Oregon Revised Statute 419B.015. CDDP incident management entries note referrals for investigation in cases involving individuals with I/DD where there is reason to suspect a crime has occurred. Local LEA and DA may collaborate with the local CDDP or OTIS in response to/investigation of complaints of abuse 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 ODHS. Per OAR, upon completion of the abuse investigation, and within 55 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 ODHS.

A copy of the abuse investigation and protective services report will be provided to ODHS 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). Protective services are those steps taken to prevent

abuse or neglect and to keep people safe. Protective services are provided by CMEs for all adults and children with intellectual or developmental disabilities (I/DD) who are eligible for or are receiving I/DD services in the community. Individuals who are able to make their own decisions may refuse to accept offered services. Protective services may include:
(a) Arranging for the immediate protection of the adult;
(b) Contacting the adult to assess his or her ability to protect his or her own interest or give informed consent;
(c) Determining the ability of the adult to understand the nature of the protective service and his or her willingness to accept services;
(d) Coordinating evaluations to determine or verify the adult's physical and mental status, if necessary;
(e) Assisting in and arranging for appropriate services and alternative living arrangements;
(f) Assisting in or arranging the medical, legal, financial, or other necessary services to prevent further abuse;
(g) Providing advocacy to assure the adult's rights and entitlements are protected; and
(h) Consulting with the facility, community program, brokerage, service provider, guardian or others as appropriate in developing recommendations and a determination of whether protective services are needed to prevent further abuse.

A redacted version of the abuse investigation report, not containing any confidential information, will be available for public inspection upon request. When the abuse investigation is concluded 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 CDDP or the Department. The CDDP 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 OTIS. The CDDP must document how the notice was provided. OAR 407-045-325 & 2017 ORS 430 requires notification of investigation results:
• Within 5 business days of approval to close an investigation, written notice of findings to:
o The alleged perpetrator (AP) & provider if not substantiated.
o The adult w/DD may be informed of the results from the case management entity (case manager) who are also informed), in lieu of a written notice.
o The adult's guardian ("legal rep" noted in the rule) is the guardian of the adult. o Waiver providers who were informed of the investigation for heath-safety & protective services.
• Within 10 days, investigator sends redacted investigation report to service provider agency or facility.
• No time listed but OTIS forwards the approved confidential report to licensing-certifications per ORS 430.745 & 430.763.
• Within 7 days for substantiated abuses, OTIS informs AP (who may be a waiver provider) of rights to review finding.

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.

ODDS is responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants.
Local CDDPs and the system's improvement committee review critical incidents and related follow-up data on a regular basis to identify emerging trends.
The CDDP incident management teams are required to convene at least quarterly to develop local and system-wide responses and implement preventive actions to address system deficiencies or emerging concerns that could potentially harm individuals served.
The ODHS incident management system incorporates incidents reported to CPS, however there will be no one under the age of 18 served in this waiver. A ODHS attorney notifies ODDS of results.
ODHS quality assurance staff compile, review and analyze performance data through CME reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to CMEs as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. ODDS staff follow-up with CMEs to ensure appropriate action is taken.
ODHS/ODDS quality assurance staff conduct comprehensive reviews of each CME's case management services once every two years.
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 ODHS to provide it. The MOCSC will have access to all supporting databases.

Appendix G: Participant Safeguards

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

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

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

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

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Restraints may only be applied in emergency situations where there is imminent risk of serious harm to the individual or others. The restraint may only be applied for as long as the threat remains critical and only when there are no less restrictive alternative methods of mitigating risk available.
When the need for a restraint in an emergency is anticipated (based on past events, condition, and nature and intensity of risks), then the individual is afforded the opportunity to engage in the Individually-Based Limitations (IBL) process and provide consent for the protective measures to be included in the person-centered service plan. The IBL process is part of the person-centered service planning which address proposed modifications to HCBS protections, including the freedom from restraint.
Restraints (referred to as Safeguarding Interventions), when indicated, must be part of a positive behavior support plan and included in the person-centered service plan, and must be directed by a medical professional or qualified Behavior Professional. The maneuver must be compliant with ODDS approved curriculum.

OAR 411-415-0070(3)(d)(A)(B) Service Planning:
(3) INDIVIDUALLY-BASED LIMITATIONS.
(d) An individually-based limitation must only include a safeguarding intervention that --
(A) Meets the definition found in OAR 411-317-0000 and complies with OAR 411-304-0150, OAR 411-304-0160, and applicable program rules.
(B) When used to address a challenging behavior, is directed in a Positive Behavior Support Plan written by a behavior professional qualified to author the safeguarding intervention according to ODDS approved behavior intervention curriculum and certification as described in OAR 411-304-0150.

411-004-0040 (3)
Individually-Based Limitations
(3) An individually-based limitation must be supported by a specific assessed need and documented in the person-centered service plan by completing and signing a program approved form documenting the consent to the appropriate individually-based limitation. The form identifies and documents, at minimum, all of the following requirements:
(a) The specific and individualized assessed need justifying the individually-based limitation.
(b) The positive interventions and supports used prior to any individually-based limitation.
(c) Less intrusive methods that have been tried but did not work.
(d) A clear description of the limitation that is directly proportionate to the specific assessed need.
(e) Regular collection and review of data to measure the ongoing effectiveness of the individually-based limitation.
(f) Established time limits for periodic reviews of the individually-based limitation to determine if the limitation should be terminated or remains necessary. The individually-based limitation must be reviewed at least annually.
(g) The informed consent of the individual or, as applicable, the legal representative of the individual, including any discrepancy between the wishes of the individual and the consent of the legal representative.
(h) An assurance that the interventions and support do not cause harm to the individual.
(i) For restraints, there is a physician or other qualified practitioner order for the use of restraint. Individual licensing authorities may adopt stricter criteria regarding the use of restraints.

Paid care providers applying the maneuver must be trained in fundamentals of
behavior support intervention and be specifically trained to apply the maneuvers to the individual. Data collection, reporting and monitoring are identified as a component of the IBL.
When restraints are applied in an emergency and are not included in an IBL, the paid provider applying the restraint must report the event to the case management entity. If there are more than three emergency applications of a physical intervention not addressed in a person-centered service plan, the planning team must meet to determine if formal behaviors support services are necessary.
Restraints are never permitted based on provider convenience or as a punitive measure.
Restraints may not include any of the following characteristics: abusive, aversive, coercive, disciplinary, demeaning, pain compliance, prone restraints, punishment, and supine restraints.

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

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

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

Appendix G: Participant Safeguards

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

3)

b. Use of Restrictive Interventions. *(Select one)*:

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

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

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restrictive interventions may only be used when based on an individual-specific need to address critical health and safety risks. Restrictive interventions must be person-centered and may only be used when there is no less restrictive alternative to address a current significant health and safety risk specific to the individual and their situation and may only be used as long as the significant risk is imminent.. Restrictive interventions may be employed to support individuals to comply with legal mandates, conditional releases, and to maintain safety.

The specific types of restrictive interventions that are permitted are individual-specific dependent upon nature and severity of risk. The use of restraint interventions are primarily reactive strategies and must be directed by a medical or behavior professional, dependent on the nature of the risk or condition presented.

Although the restrictive interventions are individualized, there are specific restrictions on interventions. Interventions used must not be abusive, aversive, coercive, for convenience, disciplinary, demeaning, prone or supine restraints, pain compliance, punishment, or retaliatory. Interventions cannot be provider or setting driven. Restrictive interventions may only be applied if they are the least restrictive method for addressing the identified risk and consent to by the individual. Practices that result in involuntary seclusion or isolation of an individual are not permitted.

Restrictive interventions which include the use of restraints by a paid caregiver apply in any setting. See "The use of restraints is permitted during the course of the delivery of waiver services under items G-2-a-i and G-2-a-ii".

All restrictive interventions will be included in the person-centered service plan.
Restrictive intervention are never permitted based on paid provider convenience or as a punitive measure. Restrictive interventions must not have the following characteristics: abusive, aversive, coercive, disciplinary, demeaning, pain compliance, punishment, or seclusionary.

Case managers authorize the use of restrictive interventions with qualifications as indicated in Appendix C of the waiver which include:
Each case manager must have knowledge of the public service system for developmental disabilities services in Oregon and at least:
~ A bachelor's degree in behavioral science, social science, or a closely related field; or
~ A bachelor's degree in any field AND one year of human services related experience; or
~ An associate's degree in a behavioral science, social science, or a closely related field AND two years human services related experience; or
~ Three years of human services related experience.
Agency, licensed, certified, endorsed, and independent providers must all have the ability to provide services adequate meet the health and safety needs of the individual. This ability includes knowledge and understanding of behavior support strategies specific to the individual. Providers must implement support strategies in accordance with the authorized Individually-Based Limitation which identifies the restrictive interventions appropriate to the individual. If restraints are an identified support strategy, then the providers must have training in ODDS-approved curriculum and have training specific to the individual in the appropriate application of intervention techniques.

OAR 411-004-0040
Individually-Based Limitations
(3) An individually-based limitation must be supported by a specific assessed need and documented in the person-centered service plan by completing and signing a program approved form documenting the consent to the appropriate individually-based limitation. The form identifies and documents, at minimum, all of the following requirements:
(a) The specific and individualized assessed need justifying the individually-based limitation.
(b) The positive interventions and supports used prior to any individually-based limitation.
(c) Less intrusive methods that have been tried but did not work.
(d) A clear description of the limitation that is directly proportionate to the specific assessed need.

(e) Regular collection and review of data to measure the ongoing effectiveness of the individually-based limitation.
(f) Established time limits for periodic reviews of the individually-based limitation to determine if the limitation should be terminated or remains necessary. The individually-based limitation must be reviewed at least annually.
(g) The informed consent of the individual or, as applicable, the legal representative of the individual, including any discrepancy between the wishes of the individual and the consent of the legal representative.
(h) An assurance that the interventions and support do not cause harm to the individual.
(i) For restraints, there is a physician or other qualified practitioner order for the use of restraint. Individual licensing authorities may adopt stricter criteria regarding the use of restraints.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

ODDS is responsible for quality assurance monitoring of plans that include the use of restrictive intervention.
Quality assurance staff compile, review and analyze performance data through CME reviews, electronic file reviews and data reports. The quality assurance staff's analysis of the performance data asks three questions: 1) Did the CME meet the required compliance rate for each question related to the areas of Health and Welfare, to include IBLs (Modifications to Conditions), and Monitoring; 2) What case specific and/or systemic corrective action is required to bring the CME into compliance; and 3) Are there immediate health and safety risks/concerns that need to be addressed. Corrective action/remediation plans are submitted to CMEs as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. ODDS staff follow-up with CMEs to ensure appropriate action is taken.
ODDS communicates information and findings to the Medicaid Agency, OHA by email to the designated OHA staff as well as through joint ODHS/OHA oversight committees. The ODDS QA reviews occur every two years. The ODHS/OHA oversight committee meets at least twice a year to review quality assurance overview reports. ODHS staff also address individual problems with designated OHA staff on an ongoing basis. OHA exercises oversight of Medicaid/CHIP programs by participating in related committees and reviewing and approving ODHS reports, documents, rules, policies and guidelines. OHA, on a continuous and ongoing basis, reviews and provides input to ODHS quality control processes for Medicaid/CHIP programs managed by the ODHS to assure proper oversight of central office and field operations. This includes ongoing review and approval of ODHS operational oversight and quality assurance activities. As designated OHA staff and the ODHS/OHA oversight committee receive reports of findings and remediation efforts, it informs the Medicaid Director and the Medicaid Operations Coordination Steering Committee thus informing executive management of OHA and ODHS.

Each use of restraint, unusual events, and incidents of significant injury to the individual must be documented and reported to the case management entity. The case manager must then review the incident report and take appropriate follow up action.
Anyone may make reports of complaints regarding unauthorized restrictive interventions. Restrictive interventions that are unauthorized may be considered abuse. All providers of ODDS HCBS services are considered mandatory reporters and must make report of any suspected abuse, including the use of unauthorized restrictive interventions.
ODDS has also adopted a formal complaints process which allows for the receipt of complaints from individuals or on behalf of individuals. The complaints may be received locally by the case management entity (CME) and must be logged and reported to ODDS. Individuals may file a complaint directly with ODDS. The source of complaints can be from anywhere and, in most cases, will be responded to by the CME. ODDS and its designees may also partner with other community resources or groups, including protective services to identify and resolve issues.
Individuals must be notified of their right to make complaints on at least an annual basis. Individuals are entitled to assistance as needed and desired to support their ability to make reports.
Additionally, Oregon has documentation requirements which also help to identify if there are issues with the application of interventions. Whenever a restraint is applied, the event must be documented by the service provider and submitted to the case management entity. If the emergency use of a restraint is applied more than three times in a six month period, the case manager must evaluate and address if there is a need for professional behavior services and/or an Individually-Based Limitation. These documentation requirements allow for tracking and reporting should there be a need to address situations where unauthorized or inappropriate restrictive interventions have been utilized.
The use of restrictive interventions is authorized by the individual's case manager. The intervention may only be authorized once the Individually-Based Limitations (IBL) (Modifications to Conditions) process has been applied. The IBL process is a part of the person-centered planning process which engages the individual in identifying safety risks and strategies to address the risk specific to the individual.
The IBL process results in the completion of the CMS documentation requirements for a Modification to the Condition of HCBS freedoms. The process includes identification of the risk, a description of the intervention, less restrictive measures that were tried but did not work, alternative strategies considered,

a plan for monitoring the effectiveness of the limitation, established timelines for review, and consent by the individual (or their legal representative, as applicable). If all of the required information is present, including verification that the intervention is the least restrictive, most appropriate option for addressing the individual-specific health and safety risk and the individual consents, the case manager may authorize the restriction. The documentation is included in the Individual Support Plan (ISP).
Some individuals may have treatment plans developed by other professional providers who support the individual in services outside of ODDS HCBS services. The individual's HCBS provider may help the individual follow recommended treatment plans, but interventions must be consented to by the individual and represent the most appropriate, least restrictive measures for addressing risk.
The use of restrictive interventions is monitored by the case manager in accordance with the individualized plan included in the ISP specific to the limitation. Some interventions will have frequent monitoring while others may be evaluated and authorized every 12 months at a minimum.
Additionally, ODDS Quality Assurance also conducts a sample review of ISPs which includes identifying if IBLs are in place and implemented in accordance with administrative rule and as described in ISPs.

ODDS requires that the CMS documentation requirements for Modification to the Conditions (IBLs in Oregon) be included in the ISP. Currently, ODDS utilizes a specific form which walks the case management entity through all of the CMS documentation requirements including: identification of the risk, a description of the intervention, less restrictive measures that were tried but did not work, alternative strategies considered, a plan for monitoring the effectiveness of the limitation, established timelines for review, and consent by the individual (or their legal representative, as applicable). If all of the required information is present, including verification that the intervention is the least restrictive, most appropriate option for addressing the individual-specific health and safety risk and the individual consents, the case manager may authorize the restriction. The documentation is then attached to and included in the ISP.

As part of the documentation process, the person-centered planning team must identify a plan for measuring the effectiveness of the intervention. This includes a plan for data collection, documentation, and tracking when interventions are implemented. The data tracking is highly customizable to be individual specific, dependent on the nature of the intervention, and to promote efficiency in the delivery of support to individuals.

Appendix G: Participant Safeguards

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

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

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

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

The use of seclusion is not included in this waiver. Case managers who oversee the ISPs and the services delivered report any use of seclusion to the CDDP, who in turn enters the information into the online incident management system. If harm is caused or there is a threat of harm, a report of abuse may be made to local law enforcement. Case managers, 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)*

- **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, and Employment providers, the provider is responsible for the ongoing monitoring of participant
medication regimens, unless the individual has a variance to administer their own medication. For individuals receiving services in their own or family home, the individual, the family, or agency/provider may be the responsible party, again, depending on support need and outlined on the service plan/job description.
Case managers are charged with providing regular monitoring of residential provider sites
licensed or certified by the Department, which are serving people with I/DD. 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 case manager 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 ODHS 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 ODHS Balancing Test form in the individual's medical record for seven years. If relevant, is the documentation present?
The CME maintains documentation in the individual's case file of medication administration errors. Errors that lead to an allegation of abuse are reported in the incident management system. 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 ODDS 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 ODDS 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.

ODHS, ODDS Licensing Unit conducts complaint investigations that are the result of a request from the CDDP or as a result of an incident report or abuse investigation reviews may be conducted in the following circumstances:
~ 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 may a review of supports and services provided to 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 of 24-hour Residential sites occur two years. Prior to licensing visits, the licensing team reviews any data stored in the incident management 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 incident management 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 incident management meeting minutes, and incident management system data during regularly scheduled meetings. It is the state's duty to assess CDDP's incident management data to identify trends relating to deaths, incidents of alleged abuse, and other serious or unusual incidents.
ODHS, ODDS Licensing visits and reviews of 24-hour Residential sites occur every two years. The ODDS Quality Assurance team compile, review and analyze performance data through CME reviews, electronic file reviews and data reports every two years.
ODHS provides requested training to CDDPs for accurate incident management reporting and utilization of incident management system data for developing Quality Improvement activities.
ODDS Quality Assurance central office staff compile, review and analyze performance data through CME reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to CMEs as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. ODDS Quality Assurance staff follow-up with CMEs 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)*

- **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).

ODHS 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. Registered Nurses (RN) may 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 sheets;
~ 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 ODDDS Licensing Unit looks for documentation in provider personnel 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.

- **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 ODDS Licensing Unit 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 CME 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.

- **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 ODHS, ODDS Licensing Unit. The ODDS Licensing Unit 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 the ODDS Licensing Unit 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 ODDS Licensing Unit records 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 ODDS Licensing Unit's computer system.
Case managers 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 incident management 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 ODDS 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.

ODHS staff compile, review and analyze performance data through CME reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to CMEs as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. ODHS central office staff follow-up with CMEs 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.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

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

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

Performance Measure:
PM28: Number and percent of waiver participants and/or guardians who were informed about the ways to identify and report abuse, neglect and exploitation. N: Number of waiver participants and/or guardians who were 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 = A random sample of the combined populations of waivers 0117, *2386*, and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify:	

	Biennially	

Data Aggregation and Analysis:

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

Performance Measure:
PM29: Number of *waiver* participants with incidents of abuse (as defined in OAR/ORS) remediated according to ODDS policy. N: Number of *waiver* participants with incidents of abuse (as defined in OAR/ORS) remediated according to ODDS policy. D: Total number of *waiver* participants *with incidents of abuse indicated*.

Data Source (Select one):
Other
If 'Other' is selected, specify:
abuse investigation entities

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:

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

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:
PM 30: Number and percent of trends identified, by ODDS, where systemic intervention was implemented. N: Number of trends identified, by ODDS, where systemic intervention was implemented. D: Total number of trends identified.

Data Source (Select one):
Trends, remediation actions proposed / taken
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:
PM31: Number and percent of waiver participants reviewed with incident reports reported timely. N: Number of waiver participants reviewed with incident reports reported timely. D: Total number of waiver participants *with incident reports*.

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 Aggregation and Analysis:

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

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

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 *waiver participants" with wrongful restraint and/or involuntary seclusion remediated according to ODDS policy. N: Number of *waiver participants* with wrongful restraint and/or involuntary seclusion remediated according to ODDS policy. D: Total number of *waiver participants* with wrongful restraint and/or involuntary seclusion.

Data Source (Select one):
Other
If 'Other' is selected, specify:
abuse investigation entities

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:

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 reviewed with risk(s) identified on the risk tool where there was evidence of the risk(s) addressed in the service plan. N: Number of waiver participants reviewed with risk(s) identified on the risk tool where there was evidence of the risk(s) addressed in the service plan. D: Total number of waiver participants reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = A random sample of the combined populations of waivers 0117, *2386*, and 0375 with confidence interval = 95%/5%/50% to determine sample size.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☒ **Other** Specify: Biennially	

Data Aggregation and Analysis:

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

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

The frequency of data collection, aggregation and analysis is biennial with site and file reviews conducted on an ongoing basis with reviews at each site every two years. The sample universe will be comprised of waiver year 1 and 2 for the #0117, *23868*, and #0375 waivers combined, to determine the statistically valid representative random sample size. The file review sample size used for all measures in Appendix D and two of the appendix G performance measures is based on a statistically valid representative random sample utilizing a 95% confidence level, 5% margin of error and 50% response distribution, as determined by the Raosoft sample size calculator found at http://www.raosoft.com/samplesize.html for the two-year cycle. This representative sample is proportioned across case management entities based on the percentage of the population served relative to the waiver population size. Half of the sample will be pulled for participants who were enrolled in waiver year one and the other half pulled for participants enrolled in waiver year two. Within the sample drawn each year of the biennial cycle, Oregon will over sample to account for multiple variable review, as well as to account for 'non-response' factors such as participants who are no longer enrolled in the waiver due to relocation out of state or death and participants whose length of enrollment within the review period is insufficient to produce results for the variables measured (e.g., service plan updated annually cannot be assessed for someone who is newly enrolled for less than 12 months).

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

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

The 0117, *2386*, and 0375 waivers meet the following five CMS conditions:
1. Design of the waivers is the same or very similar;
2. This sameness or similarity is determined by comparing waivers on the approved waiver application appendices: a. Participant Services,
b. Participant Safeguards, and
c. Quality Management;
3. The quality management approach is the same or very similar across waivers, including:
a. Methodology for discovering information (e.g., data systems, sample selection),
b. Manner in which individual issues are remedied,
c. Process for identifying and analyzing patterns/trends, and
d. Majority of the performance indicators are the same;
4. The provider network is the same or very similar; and
5. Provider oversight is the same or very similar.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Individual remediation activities will require follow-up by the ODHS Quality Management
Staff to determine that the corrective action was successfully completed by the field office, licensing or abuse investigation unit. The results of any remediation will be submitted to an inter-departmental workgroup

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

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	ODHS-Site/file reviews conducted ongoing with on-site reviews every two years OHA-reviews ODHS through regularly scheduled MOCSC meetings to identify trends that may require statewide QIS changes.

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 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 (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities*

of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Oregon Health Authority and Oregon Department of Human Services will utilize performance measures to evaluate all HCBS waivers (0117, 0375, *2386*, 0565, 40193, 40194, and 0185) as well as the 1915(k) Community- First Choice option. Continuous system improvement is the basis of the Quality Improvement System (QIS).
The QIS will utilize discovery, analysis and remediation activities as the method of ensuring that Home and Community-Based Services provided through the waivers and state plan are monitored and that necessary corrective action processes are in place. The discovery and analysis phase will occur on a two-year cycle for all Home and Community-Based services authorized under Section 1915(c) and 1915(k) authorities.
Remediation is an ongoing process that will occur during the discovery phase. Individual remediation will occur when corrective action is needed in any one geographic area or field office. System-wide remediation activities will occur every two years, when required, based on statewide discovery and analysis. Both individual and system-wide remediation activities will require a corrective action plan.
ODHS will conduct quarterly system's improvement meetings to review and analyze indicators of success related to the current ODDS strategic plan. Participant feedback on system-wide data and trends will be used to develop and prioritize strategies that lead to the implementation of system improvements. Meeting participants will include representatives from a broad stakeholder base, which includes people receiving services, family members, service providers, case management representatives, ODDS representatives and others determined appropriate or invited by the ODDS Director or designee.

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

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

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☒ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
	ODHS File reviews conducted on-site every two years OHA reviews ODHS through regular MOCSC meetings

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Staff from ODHS-ODDS, CDDPs, and Brokerages administers all services
delivered through the waiver operated by ODHS- ODDS.
ODDS, CDDPs, Brokerages and CO staff uses findings from discovery and remediation activities related to the six assurances and other parameters to establish priorities for system improvement and evaluate the effectiveness of those improvements.
ODDS, CDDPs, Brokerages and CO staff seeks input from participants, families, providers, and other interested parties/groups to find ways to deliver waiver services more effectively and efficiently and move the participant toward outcomes stated in approved plans of care.
ODDS, CDDPs, Brokerages and CO staff collects QI information from the performance measures related to the six assurances and other topic areas. They work with participants, families, providers, and others to address both concerns raised and improvement opportunities identified. ODHS staff compiles reviews and analyzes
performance data through a variety of file reviews and data reports. Corrective action/remediation plans are required as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods.
ODHS Central Office staff follow-up to ensure appropriate action is taken. A statewide report documenting key performance measures and remediation outcomes is provided to the OHA/ODHS liaison, the system's improvement committee , and the Medicaid/CHIP Operations Coordination
Committee (MOCSC). The system's improvement committee and the MOCSC reviews annual reports on key performance measures to ensure follow-up and compliance.

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

The frequency of data collection, aggregation and analysis is biennial with site and file reviews conducted on an ongoing basis with reviews at each site every two years. The sample universe will be comprised of waiver year 1 and 2 for the #0117, *#2386*, and #0375 waivers combined, to determine the statistically valid representative random sample size. The file review sample size used for all measures in Appendix D and two of the appendix G performance measures is based on a statistically valid representative random sample utilizing a 95% confidence level, 5% margin of error and 50% response distribution, as determined by the Raosoft sample size calculator found at http://www.raosoft.com/samplesize.html for the two-year cycle. This representative sample is proportioned across case management entities based on the percentage of the population served relative to the waiver population size. Half of the sample will be pulled for participants who were enrolled in waiver year one and the other half pulled for participants enrolled in waiver year two. Within the sample drawn each year of the biennial cycle, Oregon will over sample to account for multiple variable review, as well as to account for 'non-response' factors such as participants who are no longer enrolled in the waiver due to relocation out of state or death and participants whose length of enrollment within the review period is insufficient to produce results for the variables measured (e.g., service plan updated annually cannot be assessed for someone who is newly enrolled for less than 12 months).

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

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

The 0117, *2386*, and 0375 waivers meet the following five CMS conditions:
1. Design of the waivers is the same or very similar;
2. This sameness or similarity is determined by comparing waivers on the approved waiver application appendices: a. Participant Services,
b. Participant Safeguards, and
c. Quality Management;
3. The quality management approach is the same or very similar across waivers, including:

a. Methodology for discovering information (e.g., data systems, sample selection),
b. Manner in which individual issues are remedied,
c. Process for identifying and analyzing patterns/trends, and
d. Majority of the performance indicators are the same;
4. The provider network is the same or very similar; and
5. Provider oversight is the same or very similar.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID-19 pandemic and as a result of the early renewal to align waivers for consolidate reporting, a quality review report was not completed for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been submitted. Upon expiration of the Appendix K amendment, Oregon will gather data and submit the quality review in addition to any outstanding 372 reports as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 reports within 90 days up to 6 months of receiving the final quality review report and 372 report acceptance decision.

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

Appendix H: Quality Improvement Strategy (3 of 3)

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

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

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

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

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

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

OHA contracts directly with ODHS, the Organized Health Care Delivery System (OHCDS) through the IAA. ODHS, as an Organized Health Care Delivery System, in accordance with 42 CFR 447.10(b), contracts with or enters into provider enrollment agreements, interagency agreements, grants or other similar arrangements with qualified individuals, entities or units of government to furnish Medicaid/CHIP administrative or programmatic services for which ODHS has responsibility. ODHS makes payment to providers of these services.
At provider enrollment or renewal, ODHS informs providers of their right to contract directly with OHA, the single state Medicaid agency.
OHA will establish direct provider agreements and make payment to any qualified provider who does not choose to contract with ODHS as the OHCDS.
ODHS reviews the qualifications of provider applicants and assures that waiver participants are free to choose qualified providers in their area. OHA includes oversight of provider qualification measures in their reviews of ODHS performance. This includes activities to assure that subcontract providers meet all applicable Medicaid requirements for services delivered.
For the Adults' Waiver the State requires independent financial statement audits for Brokerages and non-county CDDPs and for them to maintain relevant service record information for a minimum of three years, per federal regulatory requirements. Environmental Safety Modifications, Family Training, Specialized Medical Supplies and Vehicle Modifications are all provided by qualified vendors.

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

• As necessary, assist in investigations of allegations of significant fraudulent activities within the agencies and notify management and the Audit Committee of the results.
The IAC unit facilitates the agencies' (ODHS and OHA) annual risk assessment process each year. This assessment is the basis for the annual internal audit work plan. To create each year's risk assessment summary, IAC leverages existing risk assessments from prior years and engages ODHS and OHA management and staff in additional discussions. The risks identified from prior periods are sent to responsible management for review and updates. Based on this review, and additional review by department management, a determination is made of which risks should be prioritized as top risks for audit consideration by the two agencies.
ODHS and OHA operate a joint committee, the Joint ODHS and OHA Audit Committee (Audit Committee). With the assistance of Internal Audit and Consulting Unit, the Audit Committee develops and approves an annual audit plan. The Audit Committee is comprised of executive management from both agencies and includes external partners.
The Audit Committee is a forum to address all internal and external audit issues affecting the two agencies, including the monitoring and disposition of those issues. The Audit Committee guides the functions and sets the priorities of the Internal Audit and Consulting unit within ODHS/OHA Shared Services. Committee guidance is compliant with ORS 184.360 and OAR 125-700-0010 through 125-700-0155 and in accordance with the Institute of Internal Auditor's International Standards for the Professional Practice of Internal Auditing.
Office of Payment Accuracy and Recovery
Office of Payment Accuracy and Recovery Audit staff from the Office of Payment Accuracy and Recovery (OPAR), Provider Audits Unit (PAU), a ODHS/OHA Shared Service, review payment records of Medicaid providers, by reviewing paid claims and ensuring they are supported by the progress/case note of service provided in accordance with the ISP which indicates the service to be provided. This is completed continually and ongoing, at a frequency of quarterly, based on a prioritized risk analysis and via a random sample method. The random sample is done using a stratified random sample method based on the Calvin Paper. Staff set audit priorities each year based upon assessed risk analysis. The estimate of overpayment is made utilizing a simple expansion with a standard error of the estimated overpayment and the confidence interval estimate of the total overpayment calculated from the data obtained from the sampled line items. The estimate of total overpayment is obtained by calculating the overpayment for each stratum and summing these overall strata.
A government body, an organization or an individual can trigger an audit. These auditors may conduct desk audits on on-site field audits as determined by the Auditor and PAU management. Auditors may consider other audits of the provider as described in OAR. Provider and Contractor Audits, Appeals and Post-Payment Recoveries are described in OAR 407-120-1505.
OPAR's Fraud Investigation Unit (FIU) and PAU receive reports of fraud in Medicaid programs and investigates allegations. FIU investigates allegations of consumer fraud. PAU investigates fraud allegations against providers such as billing for services not rendered, intentionally billing in duplicate, billing for higher level of services than was delivered, billing for services provided by unlicensed or otherwise ineligible practitioners, and kickback schemes.
PAU sends fraud referrals to the MFCU where there is a credible allegation of fraud. The MCFU reviews and investigates cases where there is a potential prosecution. In addition, PAU informally consults with the MFCU on other suspected cases of fraud.
OPAR maintains a hotline for anyone to report consumer fraud and provider fraud.

Additional employment information found in Main B optional.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

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

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

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

Performance Measure:
PM34: Number and percent of *waiver* claims *paid in accordance with the reimbursement methodology specified in the waiver*. N: Number of *waiver* claims *paid in accordance with the reimbursement methodology specified in the waiver*. D: Total number of *waiver* claims *paid*.

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:
PM35: Number and percent of case management claims paid *in accordance with the reimbursement methodology* specified in the waiver. N: Number of *case management claims paid in accordance with the reimbursement methodology specified in the waiver*. D: Total number of *case management* claims paid.

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:*

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 *paid* using appropriate rate methodology specified in the waiver. N: Number of approved *waiver* claims paid using the appropriate rate methodology *specified in the waiver*. D: Total number of *waiver* claims *paid*.

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:*

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

*The frequency of data collection, aggregation and analysis is biennial with site and file reviews conducted on an ongoing basis with reviews at each site every two years. The sample universe will be comprised of waiver year 1 and 2 for the #0117, *2386*, and #0375 waivers combined, to determine the statistically valid representative random sample size. The file review sample size used for all measures in Appendix D and two of the appendix G performance measures is based on a statistically valid representative random sample utilizing a 95% confidence level, 5% margin of error and 50% response distribution, as determined by the Raosoft sample size calculator found at http://www.raosoft.com/samplesize.html for the two-year cycle. This representative sample is proportioned across case management entities based on the percentage of the population served relative to the waiver population size. Half of the sample will be pulled for participants who were enrolled in waiver year one and the other half pulled for participants enrolled in waiver year two. Within the sample drawn each year of the biennial cycle, Oregon will over sample to account for multiple variable review, as well as to account for 'non-response' factors such as participants who are no longer enrolled in the waiver due to relocation out of state or death and participants whose length of enrollment within the review period is insufficient to produce results for the variables measured (e.g., service plan updated annually cannot be assessed for someone who is newly enrolled for less than 12 months).*

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

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

*The 0117, *2386*, and 0375 waivers meet the following five CMS conditions:*
1. Design of the waivers is the same or very similar;
2. This sameness or similarity is determined by comparing waivers on the approved waiver application appendices: a. Participant Services,
b. Participant Safeguards, and
c. Quality Management;
3. The quality management approach is the same or very similar across waivers, including:
a. Methodology for discovering information (e.g., data systems, sample selection),
b. Manner in which individual issues are remedied,
c. Process for identifying and analyzing patterns/trends, and
d. Majority of the performance indicators are the same;
4. The provider network is the same or very similar; and
5. Provider oversight is the same or very similar.

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

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

Individual remediation activities will require follow-up by the ODHS Quality Management Staff to determine that the corrective action was successfully completed by the field office, licensing or abuse investigation unit. The results of any remediation will be submitted to an inter-departmental workgroup for discussion, data collection and reporting. When individual and/or system-wide remediation activities are warranted based on discovery and analysis, the following time frames will be used to ensure these items are remediated in a timely manner. Because ODHS is monitoring the performance of its contractors (CMEs, and service providers)
Non-compliance will be determined by any performance measure that falls below 86% accuracy.
ODHS timelines for remediation:
Corrective Action Plans: Within 45 days of Department's identification of need for plan of correction, entities reviewed must submit a plan of correction.

Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 45 days of Department's approval of entity's plan of correction.
Completion of corrective actions: Within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff).
Timelines for systemic remediation:
Required system-wide changes: If changes require revision of administrative rules, the required changes will be completed within the time frames required by the administrative rule process, including Rule Advisory Committees (including stakeholder input), Administrative rule hearings and statutory filing time frames. If system-wide changes require waiver amendments, the process will be completed at the time of approval of the waiver amendment. This will include the 30 day public and 60 day tribal input period and 90 day approval process.
Follow-up to determine effectiveness of remediation activities will occur during the next discovery and review cycle using a comparison of compliance level pre- and post-remediation to determine the level of success with the remediation activity. After initial remediation is completed a follow-up will occur within 180 days to determine the effectiveness of the method. If additional remediation is required, it will be added to the corrective action plan.
The Quality Improvement System will ensure that all discovery and remediation activities have a process in place to ensure system improvement. The Oregon Health Authority and Oregon Department of Human Services will collaborate through inter-departmental meetings to coordinate these activities. These meetings will occur at least quarterly to report on the corrective actions and follow-up required to ensure system improvement.
Remediation strategies include training, revision of administrative processes and procedures, administrative rule revisions and waiver amendments. These strategies will be used based on the results of the discovery and analysis of the related performance measure. If compliance with the performance measure falls below 86%, a request for a corrective action plan, including activities and time lines for completion and follow-up will be required. Follow-up will include a discovery process using a valid random sample. Follow up discovery will be conducted using the standardized survey instruments and methods utilized during the initial discovery phase.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Rates guidelines for all waiver services are established and published by the Department. Costs of services are estimated based upon ODHS-published allowable rates and other limitations imposed by Oregon Administrative Rule. 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.

All rate information for employment services can be found in Main B-Optional

Direct nursing waiver services payments are based on an approved state plan rate methodology for private duty nursing. The fee schedule was set in 1993 based upon the wages received for private duty nursing services in the community in 1993. Since that time there have been periodic adjustments to these rates, based upon cost of living increases via the legislative budget process. There has been 4 periodic CPI or COLAs adjustments since 1993. The percentage of CPI or COLA is based upon the agency budget request.

Family Training – Conferences and Workshops: the actual cost of enrollment fees and educational materials.

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 an encounter methodology. Oregon will limit payment to one waiver case management contact per individual per day. If two distinct, qualifying waiver case management contacts are provided to a single individual in a single day, Oregon will only pay for one waiver case management contact for that individual. Conducting functional needs assessment is excluded from this limitation. The agency's state-wide rates were set as of 07/01/2009 and are effective for services on or after that date. The fee schedule and any annual/periodic adjustments to the fee schedule are published on the department's website at http://www.dhs.state.or.us/spd/tools/dd/cm/ODDS-Expenditure-Guidelines.pdf. The waiver case management rate is derived using the following formula: Total cost to ODHS, ODDS to provide waiver case management divided by projected biennial case management contacts.
The total cost to ODHS of providing waiver case management includes:
• Waiver case management staff salary and other personnel expenses;
• Supervisory salary and other personnel expenses in support of WCM services; and
• Indirect expenses (General government service charges, worker's comp, property insurance, etc).
The sum of these expenses is then multiplied by a percentage determined by the Legislature. ODDS will monitor waiver case management utilization to ensure services are being administered economically and efficiently. Adjustments to the waiver case management rate may be made periodically during the biennium if waiver case management contacts are materially different from beginning-of-biennium projections. New waiver case management contact rates will be established at the beginning of each state biennium period using this same methodology.

The rate guidelines are published to the web. The public may comment to the case management entity about rates or may contact the Department directly. Rates for services to be provided, as well as an estimate of the annual cost for each waiver service, are included on the Individual Support Plan, which serves to notify the participant of the cost of waiver services.

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

Reports are sent monthly to CMEs. ODHS maintains this information in a computerized data base, and reconciles the information monthly and annually to provider payment information maintained in ODHS accounting records. This document trail allows tracking of all waiver funds to individual clients.

Provider billings for Direct Nursing Services will flow directly to the Medicaid Management Information System (MMIS), reported to the State Financial Management Application (SFMA) and paid out of MMIS once the billing has been validated. Payment for validated claims are made directly (electronically) to the provider of service. MMIS is an electronic web based system that manages all aspects of client information, rate authorization, Prior Authorizations, provider claims and billing.
ODDS has access to MMIS reports and ODHS accounting records that will allow tracking and accounting reconciliation of provider paid Direct Nursing waiver funds for 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 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.
For Direct Nursing services the MMIS updates a client's Medicaid and service eligibility daily. When a service provider enters the billing claim into MMIS the system checks to verify the individuals 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.

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 CME 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 CME must create and submit the CPAs in eXPRS which authorizes the expenditure of Department funds.
For these waiver services paid through eXPRS, the CPA establish permission to expend funds for client services and establish a limit on ODHS payments.
After a service has been delivered, the Provider submits a payment claim via eXPRS. The system checks the claim against the prior authorizations, client eligibility, and if the claim complies with all authorizations, payment is made to the provider.
For Direct Nursing services, the CME authorizes the nursing services to be provided through the clients signed Individual Support Plan based on the number of monthly eligible hours as determined by a Direct Nursing Services Criteria. These services must be Prior Authorized by the CME, as well as Prior Authorized by the ODDS central office to be entered into MMIS prior to service. The process of Prior Authorization includes communication from the service provider and individual/family/Foster Provider regarding the number of hours to be requested for the next claim period (Month) submitted to the local CME for Prior Authorization. Review is done to assure the hours are approved in the client's current approved plan and does not exceed allowable limits. This information is then submitted to the ODDS Central office who does another check to assure the hours to be prior authorized for the upcoming claim period meets the ISP authorized services and does not exceed allowable limits. Once reviewed a Provider Prior Authorization specific to the requested and reviewed plan is submitted to MMIS system. The PA establishes a limit on ODHS payments.
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 CME.
Providers can only submit claims for payment after the service is delivered (the system will not allow prospective claims). To validate provider billings and to assure the services were provided the following information is required. A service provider (Nurse or Agency) must provide signed documentation of the hours worked during the claim period. The client, family member, or Foster Provider must review the documentation (time sheet) for accuracy then provide signature. This is submitted to the CME who must review the timesheet for accuracy, cross referencing the identified hours in the ISP and previously agreed prior authorization totals. This must be signed off by the case manager. The signed documentation is then sent into the ODDS central office where it is reviewed for accuracy, ensuring the hours worked were within the ISP approved hours and within the agreed Prior Authorization limits. Finally after these reviews are completed the payment authorization can be entered into MMIS to allow approval for payment.

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

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

◉ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Service authorization-enrollments and payments will be managed for all waiver services via the Express Payment and Reporting System (eXPRS). CMEs 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 ODHS, the Organized Health Care Delivery System (OHCDS) through the IAA.
ODHS, as an Organized Health Care Delivery System, in accordance with 42 CFR 447.10(b), contracts with or enters into provider enrollment agreements, interagency agreements, grants or other similar arrangements with qualified individuals, entities or units of government to furnish Medicaid/CHIP administrative or programmatic services for which ODHS has responsibility. ODHS makes payment to providers of these services.
At provider enrollment or renewal, ODHS informs providers of their right to contract directly with OHA, the single state Medicaid agency.
OHA will establish direct provider agreements and make payment to any qualified provider who does not choose to contract with ODHS as the OHCDS.
ODHS reviews the qualifications of provider applicants and assures that waiver participants are free to choose qualified providers in their area. OHA includes oversight of provider qualification measures in their reviews of ODHS performance. This includes activities to assure that subcontract providers meet all applicable Medicaid requirements for services delivered.
ODHS requires providers to maintain relevant service record information for a minimum of three years, per federal regulatory requirements. Service providers are required to permit authorized representatives of ODHS to review these records for audit purposes. Providers are required to meet the requirements stated in OAR 411.351.0000 et seq.

Direct payments will be made using the following method:
The State will establish provider agreements and make payment to any qualified provider who does not choose to contract with an OHCDS.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Case Managers employed by ODHS, CDDPs and Brokerages provide waiver case management services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ○ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ◉ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

OHA contracts directly with ODHS, the Organized Health Care Delivery System (OHCDS) through the IAA. ODHS, as an Organized Health Care Delivery System, in accordance with 42 CFR 447.10(b), contracts with or enters into provider enrollment agreements, interagency agreements, grants or other similar arrangements with qualified individuals, entities or units of government to furnish Medicaid/CHIP administrative or programmatic services for which ODHS has responsibility. ODHS makes payment to providers of these services.

At provider enrollment or renewal, ODHS informs providers of their right to contract directly with OHA, the single state Medicaid agency.

OHA will establish direct provider agreements and make payment to any qualified provider who does not choose to contract with ODHS as the OHCDS.

ODHS reviews the qualifications of provider applicants and assures that waiver participants are free to choose qualified providers in their area. OHA includes oversight of provider qualification measures in their reviews of ODHS performance. This includes activities to assure that subcontract providers meet all applicable Medicaid requirements for services delivered.

ODHS requires providers to maintain relevant service record information for a minimum of three years, per federal regulatory requirements. Service providers are required to permit authorized representatives of ODHS to review these records for audit purposes. Providers are required to meet the requirements stated in OAR 411.351.0000 et seq.

Additionally, audit staff from the Oregon 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.

ODHS auditors periodically evaluate provider financial condition and contractual compliance, review fiscal audits performed on contractors by other agencies, provide consultation to the Secretary of State's Division of Audits programs, and evaluate provider financial system issues for compliance with federal and state standards. ODHS determines the frequency of audits and also requests random records monthly. A government body, an organization or an individual can trigger an audit. ODHS auditors perform both desk reviews and on-site examinations of providers' records, facilities and operations, and other information Internal Programs. ODHS auditors provide timely, accurate, independent and objective information about ODHS operations and programs. An internal audit committee made up of representatives from each ODHS administrative unit works closely with the Audit Unit to ensure Application for 1915(c) HCBS Waiver: Draft OR.04.05.02 - Jul 01, 2014 Page 185 of 200 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). ODHS internal audits fall into two categories: classification and issue specific.

Priority for audits is set by: Risk analysis, assessing the extent of fiscal, legal, and/or public policy impact for each potential audit subject, with those having the highest level of risk given top priority; and Database analysis, which determines the quantity, magnitude, degree of aberration, and inconsistencies that exist in current application of practices. Audit Unit staff and the audit committee use the audit process to assess functions and control systems and to make recommendations to ODHS administration regarding issues such as: economical and efficient use of resources; progress meeting ODHS goals and outcomes; reliability and integrity of information; consumer health and safety; compliance with laws, regulations, policies, procedures, and contact terms; safeguarding assets, adequacy of internal controls; sound fiscal practices; effective management systems; and security and controls of information systems.

Secretary of State Audits: The Audits Division is responsible for carrying out the duties of the Secretary of 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 ODHS Audit Unit and Secretary of State Audit Division, ODHS Office of Payment Accuracy and Recovery receives reports of fraud in ODHS programs and investigates allegations. The Office maintains a hotline for anyone to report fraud and will investigate allegations against providers 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.

- (●) ***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 section 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 section 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 section 1915(b)/section 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 section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent section 1115/section 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 section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

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

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

For individuals residing in residential settings, 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.

ODHS 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 Oregon Department of Human Services (ODHS), 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 eligibility 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 ODHS, 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.

ODHS, DD Program utilizes Title IV-E as a source of funding for a portion of ODHS DD Program's initial rate for eligible children residing in DD foster care homes. ODHS uses Oregon Administrative Rules 413-090-0000 through 413-090-0050 as established by ODHS 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 ODHS, 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.

ODHS, 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. ODHS, 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.

ODHS, 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.

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	*8133.93*	*130509.91*	*138643.84*	*229165.10*	*7397.42*	*236562.52*	*97918.68*
2	*8513.83*	*135730.30*	*144244.13*	*233087.66*	*7698.87*	*240786.53*	*96542.40*
3	*8577.78*	*141159.52*	*149737.30*	*237080.21*	*8013.68*	*245093.89*	*95356.59*
4	*8633.22*	*146805.90*	*155439.12*	*241144.77*	*8343.02*	*249487.79*	*94048.67*
5	*8716.78*	*152678.13*	*161394.91*	*245282.33*	*8687.54*	*253969.87*	*92574.96*

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	23655	23655
Year 2	24346	24346
Year 3	25056	25056
Year 4	25788	25788
Year 5	26541	26541

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.*

349 Days during the waiver year.
Actual LOS from most recent 372 report (WY3).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Projections for Direct Nursing, Environmental Safety Modifications, Family Training - Conferences and Workshops, Specialized Medical Supplies and Vehicle Modifications are based on an average of the 2 years prior for WY 1 and remain stagnant for WY 2, 3, 4, and 5. The Waiver case management projections are inflated forward to be consistent with the projected number of unduplicated participants per waiver year which is based on the application of Office of Forecasting, Research and Analysis' projected growth of adults beginning with FY2023 and projecting forward at 2.9%. The cost per unit for all other waiver services uses the currently approved average rates.

For employment services:
Employment Path Services - Community & Facility Population stay at around 1000 individuals due to provider constraints and little option for facility growth assumed at general ODDS growth
Individual Supported Empl - Job Development, Placement Model assumes VR will not go into Order of Selection. Minimum number allowed is 1. This is only billed with an exception
Individual Supported Empl - Job Development, Retention Model assumes VR will not go into Order of Selection. Pre-covid annual average was 1. post Covid it jumped to 20. Model assumes it will taper from COVID levels but not go down to precovid average
Individual Supported Empl - Initial Job Coaching Model assumes 6 percent growth with growth tapering as service matures and COVID rebound slows
Individual Supported Empl - Ongoing Job Coaching Model assumes 6 percent growth with growth tapering as service matures and COVID rebound slows
Individual Supported Empl - Maintenance Job Coaching Model assumes 6 percent growth with growth tapering as service matures and COVID rebound slows
Small Group Supported Employment -Model assumes moderate growth of 5 percent but not as strong as employment growth with a tapering as COVID rebound slows. Model does not assume population will ever get back to pre-COVID numbers of over 1,000
Discovery -Billing data so far in SFY 2023 is weak so forecast for 2023 is below 2022 actuals. Model assumes moderate growth of 5 percent but not as strong as employment growth with a tapering as COVID rebound slows. Model does not assume population will ever get back to pre-COVID numbers of over 575

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 (WY3) and including actual 1915 K expenditures. The expenditures are post Part D Medicare implementation and reflect the removal of prescribed drugs. ODHS has applied a 4% inflationary increase based on application of Office of Forecasting, Research and Analysis' projected growth of adults.

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:*

Because Oregon does not operate any ICF/IID, any person choosing institutional care versus home and community-based services would be required to receive services in an ICF/IID in another state, Washington or Idaho being the most likely due to their proximity to Oregon. Oregon would be required to pay for the cost of institutional care at the rate determined by the neighboring states where the services would be provided. Therefore, the basis of Oregon's Factor G are estimated using the following process:

Factor G uses the average of Factor G calculations for the Idaho Adult Waiver and the Washington I/DD waiver for children and adults. The average inflation built into the Washington and Idaho waivers is 1.7%.

Washington #0410 effective 9/1/2022

Factor G
State derived regression formula Y = 29499.3X + 163590.5 from actual Factor G of waiver years 2015-2016 through 2018-2019 from State MMIS ($201,139, $219,347, $234,425 & $294,444) to project Factor G for WY1 of $370,086. State inflated WY2-WY5 by CPI-M of 1.95% to project WY2 of $377,303, WY3 of $384,660, WY4 of $392,161 & WY5 of $399,808. (CPI-M for WY2-WY5 is based on the August 2020-August 2021 percentage increase of 1.95% - Source: U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers: Medical Care, retrieved from FRED, Federal Reserve Bank of St. Louis; http://fred.stlouisfed.org/series/CPIMEDSL, September 2021).

Idaho #0076 effective 10/1/2017 (that was the latest waiver on the website)
Estimates were derived from actual data available in the internal MMIS system and then projected forward over the five-year waiver period, based on the historical trend.

Idaho Factor G
Year 1 88244.20
Year 2 88872.31
Year 3 89500.42
Year 4 90128.53
Year 5 90756.65

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:*

Since Oregon has no ICF/IID institutional settings in-state, Oregon is using a combined average of the G' estimates from Washington's and Idaho's 1915(c) for the ICF/ID population. Factor G' uses the average of Factor G calculations for the Idaho Adult Waiver and the Washington I/DD waiver for children and adults. The average inflation built into the Washington and Idaho waivers is 4.1%.

Washington's Waiver #0410, renewed 09-01-22, State derived regression formula Y = 392X + 1753 from actual Factor G' of waiver years 2015-2016 through 2018-2019 from State MMIS ($1,917, $2,548, $3,591 & $2,876) to project Factor G' for WY1 of $4,497. State inflated WY2-WY5 by CPI-M of 1.95% to project WY2 of $4,585, WY3 of $4,674, WY4 of $4,765 & WY5 of $4,858. (CPI-M for WY2-WY5 is based on the August 2020-August 2021 percentage increase of 1.95% - Source: U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers: Medical Care, retrieved from FRED, Federal Reserve Bank of St. Louis; http://fred.stlouisfed.org/series/CPIMEDSL, September 2021).

Idaho #0076 effective 10/1/2017 (that was the latest waiver on the website)
Estimates were derived from actual data available in the internal MMIS system and then projected forward over the five-year waiver period, based on the historical trend.

Factor G'
Year 1 10297.84
Year 2 10812.73
Year 3 11353.36
Year 4 11921.03
Year 5 12517.08

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	
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 section 1915(b)/section 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:							***6035200.00***
Employment Path Services	☐	*hours*	*1000*	*230.00*	*26.24*	***6035200.00***	
Supported Employment - Individual Employment Support Total:							***45757149.16***
Job Coaching Maintenance	☐	*hours*	*1080*	*490.00*	*31.64*	***16743888.00***	
Job Development Placement	☐					***2314.16***	

GRAND TOTAL: ***192408199.00***

Total: Services included in capitation:

Total: Services not included in capitation: *192408199.00*

Total Estimated Unduplicated Participants: ***23655***

Factor D (Divide total by number of participants): ***8133.93***

Services included in capitation:

Services not included in capitation: *8133.93*

Average Length of Stay on the Waiver: *349*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		outcome	1	1.00	2314.16		
Job Coaching ongoing	☐	hours	1440	370.00	37.79	**20134512.00**	
Job Coaching Initial	☐	hours	1040	205.00	41.47	**8841404.00**	
Job Development Retention	☐	outcome	20	1.00	1751.55	**35031.00**	
Waiver Case Management Total:							**126757683.00**
Waiver Case Management	☐	Encounter	23655	13.00	412.20	**126757683.00**	
Direct Nursing Total:							**5895536.72**
Direct Nursing	☐	quarter hour	35	11600.82	14.52	**5895536.72**	
Discovery/Career Exploration Services Total:							**312162.20**
Discovery/Career Exploration Services	☐	outcome	140	1.00	2229.73	**312162.20**	
Environmental Safety Modifications Total:							**107126.28**
Environmental Safety Modifications	☐	event	9	1.00	11902.92	**107126.28**	
Family Training - Conferences and Workshops Total:							**88.12**
Family Training - Conferences and Workshops	☐	Event	1	2.00	44.06	**88.12**	
Specialized Medical Supplies Total:							**183016.72**
Specialized Medical Supplies	☐	purchase	389	4.00	117.62	**183016.72**	
Supported Employment - Small Group Employment Support Total:							**7281440.00**
Supported Employment - Small Group Employment Support	☐	hours	680	400.00	26.77	**7281440.00**	
Vehicle Modifications Total:							**78796.80**
Vehicle Modifications	☐	event	9	1.00	8755.20	**78796.80**	

GRAND TOTAL: **192408199.00**

Total: Services included in capitation:

Total: Services not included in capitation: 192408199.00

Total Estimated Unduplicated Participants: **23655**

Factor D (Divide total by number of participants): **8133.93**

Services included in capitation:

Services not included in capitation: 8133.93

Average Length of Stay on the Waiver: 349

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Path Services Total:							**7044534.00**
Employment Path Services	☐	Hours	1029	280.00	24.45	**7044534.00**	
Supported Employment - Individual Employment Support Total:							**45900109.91**
Job Coaching Maintenance	☐	hours	1145	480.00	30.69	**16867224.00**	
Job Development Placement	☐	outcome	1	1.00	2198.45	**2198.45**	
Job Coaching ongoing	☐	hours	1526	360.00	36.65	**20134044.00**	
Job Coaching Initial	☐	hours	1102	200.00	40.23	**8866692.00**	
Job Development Retention	☐	outcome	18	1.00	1663.97	**29951.46**	
Waiver Case Management Total:							**140495896.80**
Waiver Case Management	☐	Encounter	24346	14.00	412.20	**140495896.80**	
Direct Nursing Total:							**5895628.20**
Direct Nursing	☐	quarter hour	35	11601.00	14.52	**5895628.20**	
Discovery/Career Exploration Services Total:							**320100.32**
Discovery/Career Exploration Services	☐	outcome	148	1.00	2162.84	**320100.32**	
Environmental							**107126.28**

GRAND TOTAL: ***207277809.20***

Total: Services included in capitation:

Total: Services not included in capitation: *207277809.20*

Total Estimated Unduplicated Participants: ***24346***

Factor D (Divide total by number of participants): ***8513.83***

Services included in capitation:

Services not included in capitation: *8513.83*

Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Safety Modifications Total:							
Environmental Safety Modifications	☐	event	9	1.00	11902.92	**107126.28**	
Family Training - Conferences and Workshops Total:							**88.12**
Family Training - Conferences and Workshops	☐	Event	1	2.00	44.06	**88.12**	
Specialized Medical Supplies Total:							**183016.72**
Specialized Medical Supplies	☐	purchase	389	4.00	117.62	**183016.72**	
Supported Employment - Small Group Employment Support Total:							**7252512.05**
Supported Employment - Small Group Employment Support	☐	hours	707	395.00	25.97	**7252512.05**	
Vehicle Modifications Total:							**78796.80**
Vehicle Modifications	☐	event	9	1.00	8755.20	**78796.80**	

GRAND TOTAL: **207277809.20**

Total: Services included in capitation:

Total: Services not included in capitation: 207277809.20

Total Estimated Unduplicated Participants: **24346**

Factor D (Divide total by number of participants): **8513.83**

Services included in capitation:

Services not included in capitation: 8513.83

Average Length of Stay on the Waiver: 349

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Path Services Total:							**8247492.00**
Employment Path Services	☐	Hours	1059	300.00	25.96	**8247492.00**	
Supported Employment - Individual Employment Support Total:							**48024462.45**
Job Coaching Maintenance	☐	hours	1213	460.00	31.31	**17470353.80**	
Job Development Placement	☐	outcome	1	1.00	2198.45	**2198.45**	
Job Coaching ongoing	☐	hours	1618	350.00	37.39	**21173957.00**	
Job Coaching Initial	☐	hours	1169	195.00	41.03	**9352993.65**	
Job Development Retention	☐	outcome	15	1.00	1663.97	**24959.55**	
Waiver Case Management Total:							**144593164.80**
Waiver Case Management	☐	Encounter	25056	14.00	412.20	**144593164.80**	
Direct Nursing Total:							**5895628.20**
Direct Nursing	☐	quarter hour	35	11601.00	14.52	**5895628.20**	
Discovery/Career Exploration Services Total:							**346357.70**
Discovery/Career Exploration Services	☐	outcome	157	1.00	2206.10	**346357.70**	
Environmental Safety Modifications Total:							**107126.28**
Environmental Safety Modifications	☐	event	9	1.00	11902.92	**107126.28**	
Family Training - Conferences and Workshops Total:							**88.12**
Family Training - Conferences and Workshops	☐	Event	1	2.00	44.06	**88.12**	
Specialized Medical Supplies Total:							**183016.72**
Specialized Medical Supplies	☐	purchase	389	4.00	117.62	**183016.72**	

GRAND TOTAL: **214924856.17**

Total: Services included in capitation:

Total: Services not included in capitation: **214924856.17**

Total Estimated Unduplicated Participants: **25056**

Factor D (Divide total by number of participants): **8577.78**

Services included in capitation:

Services not included in capitation: **8577.78**

Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Small Group Employment Support Total:							**7448723.10**
Supported Employment - Small Group Employment Support	☐	hours	721	390.00	26.49	**7448723.10**	
Vehicle Modifications Total:							**78796.80**
Vehicle Modifications	☐	event	9	1.00	8755.20	**78796.80**	

GRAND TOTAL: 214924856.17
Total: Services included in capitation:
Total: Services not included in capitation: 214924856.17
Total Estimated Unduplicated Participants: 25056
Factor D (Divide total by number of participants): 8577.78
Services included in capitation:
Services not included in capitation: 8577.78
Average Length of Stay on the Waiver: 349

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Path Services Total:							**8658960.00**
Employment Path Services	☐	hours	1090	300.00	26.48	**8658960.00**	
Supported Employment - Individual Employment Support Total:							**50765453.30**
Job Coaching Maintenance	☐	hours	1274	450.00	31.93	**18305469.00**	

GRAND TOTAL: 222633566.92
Total: Services included in capitation:
Total: Services not included in capitation: 222633566.92
Total Estimated Unduplicated Participants: 25788
Factor D (Divide total by number of participants): 8633.22
Services included in capitation:
Services not included in capitation: 8633.22
Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Job Development Placement	☐	outcome	1	1.00	2198.45	2198.45	
Job Coaching ongoing	☐	hours	1699	350.00	38.13	22674004.50	
Job Coaching Initial	☐	hours	1227	190.00	41.86	9758821.80	
Job Development Retention	☐	outcome	15	1.00	1663.97	24959.55	
Waiver Case Management Total:							148817390.40
Waiver Case Management	☐	Encounter	25788	14.00	412.20	148817390.40	
Direct Nursing Total:							5895628.20
Direct Nursing	☐	quarter hour	35	11601.00	14.52	5895628.20	
Discovery/Career Exploration Services Total:							371286.30
Discovery/Career Exploration Services	☐	outcome	165	1.00	2250.22	371286.30	
Environmental Safety Modifications Total:							107126.28
Environmental Safety Modifications	☐	event	9	1.00	11902.92	107126.28	
Family Training - Conferences and Workshops Total:							88.12
Family Training - Conferences and Workshops	☐	Event	1	2.00	44.06	88.12	
Specialized Medical Supplies Total:							183016.72
Specialized Medical Supplies	☐	purchase	389	4.00	117.62	183016.72	
Supported Employment - Small Group Employment Support Total:							7755820.80
Supported Employment - Small Group Employment Support	☐	hours	736	390.00	27.02	7755820.80	
Vehicle Modifications Total:							78796.80
Vehicle Modifications	☐	event	9	1.00	8755.20	78796.80	

GRAND TOTAL: 222633566.92

Total: Services included in capitation:

Total: Services not included in capitation: 222633566.92

Total Estimated Unduplicated Participants: 25788

Factor D (Divide total by number of participants): 8633.22

Services included in capitation:

Services not included in capitation: 8633.22

Average Length of Stay on the Waiver: 349

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Path Services Total:							**9083463.00**
Employment Path Services	☐	hours	1121	300.00	27.01	**9083463.00**	
Supported Employment - Individual Employment Support Total:							**54373811.80**
Job Coaching Maintenance	☐	hours	1338	450.00	32.57	**19610397.00**	
Job Development Placement	☐	outcome	1	1.00	2198.45	**2198.45**	
Job Coaching ongoing	☐	hours	1784	350.00	38.90	**24289160.00**	
Job Coaching Initial	☐	hours	1288	190.00	42.69	**10447096.80**	
Job Development Retention	☐	outcome	15	1.00	1663.97	**24959.55**	
Waiver Case Management Total:							**153162802.80**
Waiver Case Management	☐	Encounter	26541	14.00	412.20	**153162802.80**	
Direct Nursing Total:							**5895628.20**
Direct Nursing	☐	quarter hour	35	11601.00	14.52	**5895628.20**	
Discovery/Career Exploration Services Total:							**397073.06**
Discovery/Career Exploration Services	☐	outcome	173	1.00	2295.22	**397073.06**	
Environmental							**107126.28**

GRAND TOTAL: ***231352106.78***

Total: Services included in capitation:

Total: Services not included in capitation: *231352106.78*

Total Estimated Unduplicated Participants: ***26541***

Factor D (Divide total by number of participants): ***8716.78***

Services included in capitation:

Services not included in capitation: *8716.78*

Average Length of Stay on the Waiver: 349

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Safety Modifications Total:							
Environmental Safety Modifications	☐	event	9	1.00	11902.92	**107126.28**	
Family Training - Conferences and Workshops Total:							**88.12**
Family Training - Conferences and Workshops	☐	Event	1	2.00	44.06	**88.12**	
Specialized Medical Supplies Total:							**183016.72**
Specialized Medical Supplies	☐	purchase	389	4.00	117.62	**183016.72**	
Supported Employment - Small Group Employment Support Total:							**8061300.00**
Supported Employment - Small Group Employment Support	☐	hours	750	390.00	27.56	**8061300.00**	
Vehicle Modifications Total:							**87796.80**
Vehicle Modifications	☐	event	9	1.00	9755.20	**87796.80**	

GRAND TOTAL: **231352106.78**

Total: Services included in capitation:

Total: Services not included in capitation: 231352106.78

Total Estimated Unduplicated Participants: **26541**

Factor D (Divide total by number of participants): **8716.78**

Services included in capitation:

Services not included in capitation: 8716.78

Average Length of Stay on the Waiver: 349