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Oregon Project Independence – Medicaid

Frequently Asked Questions

Quality Assurance

What is the Quality Assurance/Quality Control process?

This will be modeled on the current Medicaid review. APD will determine if the assessment meets eligibility requirements and will determine if the service plan meets the assessed need. Additionally, the review will ensure that the appropriate case manager contacts have taken place.

What QA is required by CMS and what will it look like?

Based on the draft Special Terms and Conditions, we believe it will be like the current QA process. This includes a review of eligibility determinations, functional needs assessment and service planning to meet the functional needs assessment. The exact process will be developed jointly shortly after roll-out. Please see above for more information.

Transition to OPI-M/Soft Launch

Do all existing LTSS SPPC consumers need to be notified of OPI-M benefit when approved?

APD CO will handle any outgoing communication to current consumers. State Plan Personal Care (SPPC) and Title XIX consumers will be made aware of the new program during their annual reassessment once OPI-M is implemented. Consumers may contact the office and request information about OPI-M before their annual reassessment. Consumers may request an early assessment to determine if they are eligible for OPI-M.

What notification will be sent to consumers? Both OPI and current LTSS?

This is still being developed. APD CO will provide details when the soft launch has been finalized jointly with the planning committee.

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Is there an OBI report for in home care agencies, current LTSS consumers by total assigned hours to review those in OPI-M limits?

The intent is not to move consumers early on but rather to inform consumers at their reassessments. No outreach is needed at this time.

What are the communication needs between eligibility case management and service case management?

This needs to be decided locally. Workgroups and discussions are already in place. At a minimum the local offices/districts should determine how to refer cases, how to communicate if a new eligibility assessment is needed or if the consumer's financial situation has changed. APD CO is happy to help with the development of these processes but believes that local design and partnership are critical to the success of OPI-M.

What is the communication plan between AAA and APD?

Communication plans should be developed locally to meet local area needs. We highly recommend that the AAA and APD office meet to develop this process before implementation and schedule regular meetings during implementation. APD CO is happy to help coordinate. Draft processes have been shared and can be shared again if requested

What are the rollout dates?

Rollout dates will be determined jointly once approval from CMS is received. As previously discussed, we expect to begin implementation 90 days after final approval.

What is the transition plan and support?

OPI-M implementation planning is in progress and being discussed with AAAs and APD local districts. However, if the question is about transitioning current OPI consumers, this will be covered in the launch plan. Each OPI consumer will need to be assessed by Medicaid to ensure that they meet the OPI-M eligibility requirements.

What is the goal implementation date?

As discussed earlier in our planning efforts, we think implementation will start 90 days from final CMS approval.

Is there flexibility to phase the rollout based on location?

As planned with AAAs and APD local offices, we are not intending to implement this all at once. A phased in approach based on population (e.g., individuals on the OPI waitlists) will be used but it will be for the entire state.

How many consumers are we expecting?

By the end of the 5-year demonstration, we estimate 4,000 to 5,000 individuals including current OPI consumers. APD estimated that the fastest growth rate is in the first two years and an 1.9% growth rate annually after the first two years.

Have we run numbers on how many SPPC, or title XIX consumers could move to OPI-M?

Yes, we have looked the potential numbers, but we cannot determine the behavior of individuals so definitive counts are difficult to project. We will continue to assess this caseload impact.

What does pre-screening mean for type A's?

APD Central Office will conduct pre-screening of the current OPI consumers to ensure that individuals meet the eligibility requirements.

Eligibility

How will information be routed when tasks are being pulled by VEC, SSP and SFO?

When someone is applying for benefits through the ONE system, including OPI-M, the normal eligibility process will take place. For individuals eligible for “traditional” LTSS, enrollment in OPI-M will occur when the consumer is selecting from their service option through a choice counseling process. If the individual is denied in ONE for being over income or over resources, or if the case manager determines the individual does not meet SPL 1 – 13, the ECM will be responsible for determining if the individual meets the income and resource standards for OPI-M.

The Central Coordination Unit (CCU) has a process in place to identify cases that have been denied in ONE but may be eligible for OPI-M. They will send an email to the local office requesting an eligibility case manager follow-up with the individual and determine if they are eligible for OPI-M.

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How are disqualifying transfers being reviewed and considered?

The potential for disqualifying transfers of assets will be reviewed in the same manner as the current LTSS eligibility process.

What is the form for CM eligibility determination?

The SPAN will be used for eligibility determination.

How do we do AVS for those not in ONE?

Rights to the Asset Verification System (AVS) portal will be granted to ECMs.

Will EAU be wiped for those that transfer from LTSS to OPI-M?

Based on the draft Special Terms and Conditions from CMS, consumers receiving benefits under OPI-M will not have an EAU claim for medical or service benefits for the costs incurred from the time they enroll in OPI-M going forward. For individuals with prior benefits, those costs will still be part of an estate recovery claim.

How is MED going to be incorporated?

The 1115 application for OP-M defined the eligible population as those over age 65 and those over age 18 with a physical disability. The current exclusion of serving individuals with a mental illness applies to OPI-M. ECMs will need to follow the current process for individuals between the ages of 18 and 64 who have a diagnosis of a mental illness.

What is the OPI-M only eligibility route?

For individuals who only want OPI-M and clearly state that decision, a referral should be made to the ECM at the local APD office and the internal designee in the Type B AAAs. However, we highly recommend that all individuals be referred for a full Medicaid determination through ONE.

What is the workflow between financial and service eligibility?

For individuals applying for standard Medicaid, the process stays the same.

Can you use a title XIX assessment for OPI-M if they are not going with title XIX?

A XIX assessment can be used for an OPI-M benefit and service authorization. However, an SPPC assessment cannot be utilized. If an

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SPPC consumer wishes to move to OPI-M, a new CAPS must be completed. For OPI-M consumer who choose to enroll in Title XIX, a new assessment will be required/

Service Providers

Can we get information on the current in-home care agency use?

All but two of the IHCAs that are serving OPI consumers are enrolled as Medicaid providers. We will be working with the AAA that has non-Medicaid enrolled in-home care agencies (IHCAs) to determine if we can enroll those providers. Consumers can choose HCWs or an IHCA. For current Medicaid in-home consumers, approximately 23% are receiving services from IHCAs.

Please note that APD is starting a new HCW recruitment campaign. We hope this will alleviate any barriers to caregivers.

Can we do batch provider payments?

This will not work in OPI-M. Payments for HCWs will be authorized in PTC and Mainframe (MF) and paid in the MF. Payments for IHCAs will be authorized and paid in MMIS.

What are the payment methods for the various services? Assistive technology, transportation, etc.

Payment systems included:

- PTC and Mainframe for payments to homecare workers. Mainframe for adult day centers and home delivered meals.
- MMIS for payments to in-home care agencies, ERS providers, and long-term community care RNs.
- APD central office will pay directly for assistive technology, and environmental modifications.
- For community transportation, the local office will authorize hours and mileage in the Mainframe (MF) for HCWs and in MMIS for in-home care agency.

Instructions on how to use these systems will be provided.

How do we get vendor provider numbers?

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For HCWs, IHCAs and other providers, the provider numbers are in Oregon Access. For other providers, you can find a list on the Case Management page.

If you are asking how new providers can enroll, please work with the local Medicaid office to enroll any new providers.

How do we bill or invoice AAA contracts without a provider number?

If this is about services that are not authorized to a direct caregiver, such as meals or caregiver support, the AAA will need to be enrolled as a Medicaid provider. For more traditional in-home supports such as homecare workers and IHCA, those providers will have a Medicaid provider number. APD is happy to discuss with AAAs that have concerns about this.

How many home delivered meals can be approved (one or two?)

SCMs can authorize up to two meals a day.

Will MMIS ever bill for home delivered meals?

We are not sure if or when we will be adding HDMs to MMIS.

Can AAA be paid for evidence-based health promotion?

Medicaid does not generally allow case management entities who authorize services to provide other services for which they would be paid. CMS has defined this in federal regulations as conflict free case management. It is intended to ensure that case managers within organizations that authorize services are not unduly influenced to authorize services that may generate revenue for the case management entity.

There are exceptions and processes that can be used certain circumstances. As an example, if there can be an administrative separation between the case management staff, including supervisors, and direct services staff, including their supervisors, it may address the requirements in CFR. Exceptions can also be made when there are no other direct service providers in the area. All exceptions will need to be approved by CO.

AAAs interested in being paid for OPI-M services should work with their APD Community Services and Supports liaison to explore options and complete any required documentation or contract adjustments.

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Service Planning

Can we name the Service plan form something other than SPAN?

The name has been changed to PLAN, Person Led Assessment and Notice.

What is the eligibility notice for consumers?

A SPAN is completed and sent by the ECM and a PLAN is completed and sent by the SCM. The individual will sign the PLAN and keep a completed copy for their record. Remember the PLAN should be developed with the consumer.

What is the role of the type A's in service bids and payments?

The AAAs will be responsible for obtaining bids for some services such as environmental modifications or chore services. APD CO will be responsible for payments. All service payments will be paid either from IT systems or manually by CO. AAAs will not be responsible for any direct payments.

How time consuming is the service planning piece?

We expect it to take 1 to 2 hours to complete a person-centered service plan. Copies of the PLAN will need to be saved to reflect any changes. APD will provide additional instructions on how the PLAN should be saved.

Is there an hour cap on OPI-M?

The maximum hours will be limited to 40 hours per pay period. However, through the person-centered service planning process less hours may be authorized by the SCM. There will be no exception to the 40 hours per pay period. SCMs can discuss other program options if the individuals needs cannot be meet with their natural supports and the hours and service options available with OPI-M.

Can you please clarify pay periods?

Pay periods will be the same used for HCWs. It is a two-week period that starts on a Sunday and ends on a Saturday. The schedule is posted on the CM tools web page.

Is the service list and definitions finalized?

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Yes, this has been approved by CMS. They will be posted in the OPI-M section of the Case Management Tools webpage prior to implementation.

Who does the service plan?

CAPS and financial are done first by ECM. Then the SCM creates the service plan, with the consumer, and completes the resulting PLAN.

Do you have to fill out the SPAN (service plan and notice)?

ECMs will complete the SPAN and SCMs will complete the PLAN.

What happens if someone picks an unsafe care plan?

An individual always has choices. Local offices will need to determine if the care plan is truly dangerous or if it just is not sufficient. As an example, a consumer may choose to receive OPI-M when they need more hours than allowed and full Medicaid would be a better option. OPI-M may be better than no services. However, if the consumer cannot safely manage an in-home plan, is abusive to caregivers or allows dangerous individuals to stay in the home, services may not be appropriate. Please see the Mitigation and Due Process Guide.

Is there mileage on the Service plan for home care workers?

Yes. Mileage to meet the needs of the consumer can be authorized to homecare workers and IHCAs. Mileage should be reasonable and meet an assessed need of the individual. Mileage should be identified in the PLAN and entered on the 546 in Oregon ACCESS.

Is there a different service planning process for home delivered meals? Do we need a nutrition assessment?

Home delivered meals will need to be authorized in OregonAccess. For security reasons, another staff person will need to create the HDM voucher in the Mainframe (MF). The MF will then send a voucher to the HDM provider. After services are complete, the MHDM provider will submit the voucher for payment. The service case manager will verify that the meals were provided. Then the local office staff enter the voucher information into MF and the MF pays the provider. Consumers should receive a nutrition assessment since the Medicaid Home Delivered Meals benefit includes that assessment.

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Case Management

Who holds the case management or medical management?

Consumers receiving OPI-M only, without Medical, will be served by the AAA. Consumers with medical benefits will receive their SCM from APD office or Type B AAA. For consumers who have been engaged with the AAA, e.g., enrolled in OPI, receiving OAA services, on the OPI Waitlist, will be served by the AAA.

The goal is to increase the number of individuals we serve without unbalancing the system. As we move forward through implementation, APD and the AAAs will continue to work together to make changes as necessary to who should be serving whom.

What is the type A role in the payment process?

The office authorizing benefits, which include Type A's, will be responsible for authorizing payments in the required systems. For example, the Mainframe is used to authorize payments for HCWs and MMIS is used for IHCAs. Payments for services that are not ongoing, e.g., environmental modifications, will be paid by CO but the request will need to come from the AAA.

Are there talking points being created for ECM and SCM?

APD is developing guides and charts as identified by the implementation workgroups. A program comparison chart has been created to support staff when discussing what program will best meet the individuals need.

Are the eligibility case managers (ECMs) going to have to capture the details like the SPAN and what if they don't match when the service case manager (SCM) does it?

Yes, ECMs need to capture details that impact eligibility in sufficient detail that an individual who is denied services understands why they were denied. APD will be requiring the same information for OPI-M as we do for Title XIX. This information may differ than the details captured when building the individuals service plan on the PLAN. If SCM receives information or sees something that will impact the eligibility of the individual, they will need to connect with ECM to discuss if the individual needs to be reassessed early.

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What happens when people want to move to a different program?

Every situation will be different. If an individual wants to move from OPI-M to Title XIX a new eligibility determination will need to occur. The individual will need to go through ONE because there are different financial eligibility requirements. The individual will also need to be assessed. The assessment ensures hours will be determined accurately and if moving into a CBC or NF setting, the correct provider rate will be identified.

Are there specific elements to be asked during contacts?

For monthly or quarterly contacts, it should be a value-added conversation. This may include discussions about risk mitigation issues, service planning updates or changes, natural support involvement, or similar topics. The goal of the contact is to ensure that the service plan is meeting the needs of individual. It can also include discussions on other issues impacting the individual's health and well-being and identify the need for referrals to other services or entities. The conversation should always be person-centered.

How will CMs interact with caregivers versus consumer?

The focus of the services is the consumer. However, OPI-M is also intended to maintain the caregiving relationship. Communication should be person and family centered. Conversations should be driven by the consumer and SCMs should take their cues. However, the service plan should be developed to support the caregiver as well and ensure that the caregiver can access the caregiver support services available through OPI-M if they would like to do so.

If a client doesn't wish to receive OPI-M but there is a request for caregiver services what happens?

At this time, they can be served through Older Americans Act (OAA) Family Caregiver Support Program at the AAAs. It is also important to note that a consumer can be eligible for OPI-M but chose only those services that support their caregiver. As an example, they may not want a HCW or IHCA to perform any tasks but they do want their caregiver to receive training and be able to attend caregiver support groups.

How do we staff urgent cases?

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APD is developing an OPI-M mailbox for emails about OPI-M. This will include urgent cases. Additionally, the redacted information can be staffed in the huddles that are being scheduled.

Funding

What is the impact to OAA services and funding?

There will be no impact on OAA services and funding. The OAA funding is a federal block grant, with the $5 million for original OPI designated as the maintenance of effort funds for the federal grant allocation.

Is there funding for ADRC screening and how does that play in with Medicaid match?

There is no funding from OPI-M to Aging and Disability Resource Connections (ADRC) for screening. ADRCs can still claim Medicaid match through Oregon Medicaid Administrative Claiming (OMAC) including for those individuals who may enroll in OPI-M.

IT and computer systems

Can we have a dedicated IT staff person through this process?

APD does not have dedicated IT staff to support this project. If the issue is about rights or security, you will start by contacting your RACF/security rights administrator. You can also reach out to APD.Security-Requests@odhsoha.oregon.gov.

For policy, training needs, or technical questions send an email to OPI-M email box.

Can we have clear instructions on how to get into all the systems?

Yes, instructions will be provided including on how staff will gain access to systems.

Who is our go to person to ensure people have all the rights they need?

If the issue is about rights or security, you will start by contacting your RACF/security rights administrator. You can also reach out to APD.Security-Requests@odhsoha.oregon.gov.

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For policy, training needs, or technical questions send an email to OPI-M email box.

Can we have AAAs in Teams?

We are working on a solution for this.

Are there situations when staff can talk to consumers even if they say no?

If you are speaking about risk monitoring or case management contacts, the case manager should document the refusal to talk with the case manager in narration. If you mean eligibility determinations, if the consumer refuses to apply, and does not have a guardian, we cannot do anything. If this is about something different, please submit a question.

What happens with the OPI pilot?

As consumers move to OPI-M, we will phase out the OPI-pilot and the AAAs will be able to serve individuals over 18 who meet 411-015 eligibility criteria. In the short term, the pilot will remain.

Where does the CIL and ERC come into this work?

There are no changes to the Centers for Independent Living (CILs) or the Employer Resource Connect (ERC). Please note that the AAAs cannot subcontract the work to the CILs or other entities.

Training

What will the training plan will be?

The training plan is comprised of:

- In person trainings through Oregon Association of Area Agencies on Aging and Disabilities (O4AD) Quarterly meetings
- Individual training modules beginning with an updated version of Module 1, an overview of the program basics.
- Additional modules and tutorials are in development.
- APD Central Office (CO) will host daily huddles for staff and managers for the first months of the OPI-M roll out. And then weekly until local offices determine the huddles are no longer necessary.

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How will we prioritize training for eligibility? Services? What is the training sustainability plan?

Training will be comprehensive with targeted training for each part of the system. As an example, eligibility training overview will be for all staff, but detailed training will be specific to the staff determining eligibility.

Additional training will be available to Type A Area Agencies on Aging (AAAs) who have not performed case management in the manner expected by the Centers for Medicare and Medicaid Services (CMS). In addition to online training modules, the plan includes question and answer sessions and technical support. Trainings will be revised as needed. Additional training will be added as needed to support the implementation of the program as determined by the collaborative implementation team that includes AAAs and APD local offices in addition to Central Office.

What is the timeline for training and the time commitment?

The timeline is not yet determined. We estimate that the training will be three to five hours of online module training sessions divided among different modules. This is in addition to the Q&A sessions and technical support questions that are after the Module sequence. Huddles will start the week prior to implementation.

Can training be done as a group or does it need to be done individually?

Online training modules are to be reviewed individually. Registration is done in Workday Learning. Each person needs to register individually to receive credit for the training.

As a manager/supervisor, can I register my full team for this training?

Yes, you can register your team to take trainings through Workday. Here are links to the instructions: Enroll My Team - Learning Content and Mass Enroll Learners into Digital Courses and Programs

How long is the financial training?

This training program is still in development. Module 1 is approximately 45 minutes. APD expects that there will be 4 or 5 modules. Additionally, AAA staff can attend any Medicaid classes and any OPI classes.

How do we support contracted partners with training sustainability?

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AAA subcontractors may take the trainings. Online self-paced training is self-paced and does not require the time, risk or cost associated with travel.

Can you retake trainings in Workday?

Yes.

How do we request needed trainings?

To request trainings or suggest new trainings, please email TrainingUnit.ServicesSupports@odhsoha.oregon.gov.

Statements:

- Initial assessment and reassessment for eligibility will be done at APD local office for areas with Type A AAAs.
- Direct quarterly contacts are similar to wavered case management contact requirements. These contacts should be value add for the consumer and is intended to ensure that their ed or provide clarity and must be two-way communication.
- APD and AAAs do not need to conduct a “change in condition assessment” unless the ECM or SCM believe the change would make someone ineligible.
- Mileage will be captured in Oregon ACCESS.
- Home delivered meals will be paid through voucher using the same process as Medicaid home delivered meals.
- APD will communicate with type A AAAs when CAPS occurs.
- Individuals may be working with 3 different staff. An eligibility worker for a financial decision, an ECM and a SCM.
- APD is testing all IT systems to ensure they are working as intended prior to roll out.
- APD needs to forecast for home delivered meal growth if two meals a day. APD has seen little growth in MHDMs since this has been allowed in the XIX program. We do not think it will greatly impact the AAAs.
- The federal requirement that an eligibility decision is made within 45 days applies to OPI-M.

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Suggestions:

- *Enhance NWD/Medicaid match at ADRC to take all calls as front door and screen for all services with more money to support staff.*
    - This is not possible without legislative approval and funding.
- *Get ONE access for all AAAs.*
    - APD is working on view rights for the Type A AAAs and MCADVS district centers.
- *Run all eligibility through ONE.*
    - We do not think this is feasible any time in the next 4 years due to other priorities. Additionally, there would be no way for the “tasks” to be assigned to APD or AAA offices.