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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The maximum number of users for waiver case management has increased at renewal due to rising caseloads attributed to Oregon's growing population of aging and people with disabilities. In Appendix B, the Freedom of Choice language was updated to indicate a choice form is used and case managers are responsible for documenting choice. In Appendix C, Transition Services language was revised to clarify community transitions are to a more independent/less restrictive living arrangement. In Appendix J, cost estimates were updated.

The December 2025 HCBS Review identified APD met five out of six assurances. APD did not meet the Service Plans are Responsive to Waiver Participant Needs assurance, as some performance measures were below the compliance threshold. In response, APD gathered a team to discuss these performance measures and identify a plan for remediation. At the time of this renewal application submission, statewide, case managers are undergoing mandatory training on performance measures 18, 19, 23, 24 and 25 through five online modules. APD is also updating its IT system to make sure that case managers document the requirements in the performance measures and is creating new tools to track and address authorized but unused services.

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*):

Aged and Physically Disabled Waiver

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: OR.0185
Draft ID: OR.008.08.00

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

Regular Waiver

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

01/01/27

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:

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

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.

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

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

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

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

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

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

Service Delivery Methods
Case Management services are delivered through ODHS local offices, Area Agencies on Aging (AAAs), willing Oregon Tribes and NARA. Housing Support Services are delivered through ODHS local offices, AAAs, and willing Oregon Tribes.

The Oregon Health Authority (hereinafter referred to as OHA) is the Single State Medicaid/CHIP agency (SSMA) responsible for the administration of programs funded by Medicaid and CHIP in Oregon. The Oregon Department of Human Services is the Operating Agency responsible for the operation of certain programs under Medicaid, which includes home and community-based waivers.

OHA and ODHS, by written inter-governmental agreement (IGA), 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.

An excerpt from the IGA:
3.0
"OHA and ODHS recognize responsibilities of OHA as the single state Medicaid/CHIP agency which retains ultimate administrative authority and responsibility for the operation and oversight of the Medicaid/CHIP program. OHA must ensure that all funds expended under its authority are spent appropriately and in accordance with federal and state law, federal and state regulations, the State Plan, State Plan amendments and waivers. At the same time, both agencies recognize that, consistent with the general principles upon which this agreement is based, ODHS, as the operating agency, conducts delegated administrative and operational activities and functions, and provides programmatic expertise for intrinsic elements of the Medicaid/CHIP program. OHA exercises administrative discretion in the administration or supervision of the Medicaid/CHIP program pursuant to 42 C.F.R. Sec. 431.10(e). OHA will provide oversight to ODHS, as the operating agency, in conducting the administrative and operational functions identified in this agreement."

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:

Public comment is solicited according to public notice requirements as described in 42 CFR 441.304(f)(1)-(4) and/or 42 CFR 447.205. For substantive changes to the waiver, the following process is used:
1)Public comment is solicited by posting of a public notice and news release of ODHS intent to amend or renew a waiver. The notice is posted electronically at: https://apps.oregon.gov/oregon-newsroom/OR/ODHS/Posts.
Notices are also sent electronically to FlashAlert service. FlashAlert reaches major news organizations statewide.
A physical copy of the notice will also be posted in each ODHS/AAA local office.
The contents of the public notice include a description of the proposed change, a request for public comment, the proposed effective date, and a copy of the proposed waiver application. It will also include instructions for obtaining a physical copy of the documents. The notice also includes the time period for submission of public comments and the contact information for submitting comments. A physical copy of the documents will be made available to the public for review in each ODHS/AAA local office.
After the comment period has ended, the comments are compiled, summarized and provided to Department management to determine if any changes are required based on input received. Any changes made to the proposed waiver application are made prior to submission to CMS. The submitted application is made available to the public after submission.
2)Public input is solicited in a timeframe that provides the public sufficient time to comment and the Department sufficient time to summarize and make any necessary changes prior to submission of any waiver application that proposes substantive changes. The public comment period provides the public 30 days to comment on substantive changes and ensures that the Department can summarize and make any needed changes to the waiver application prior to submission. The process is completed within 30 days prior to implementation of the proposed change or submission of the waiver application to CMS, whichever comes first.
3)This process is used for both existing waivers that have substantive changes proposed, either through the renewal or the amendment process, and new waivers.
4)The Nine Federally Recognized Tribes in Oregon and the Urban Indian Health Program are notified and provided adequate time to provide input in accordance with Presidential Executive Order 13175 and the OHA-ODHS Tribal Consultation and Urban Indian Health Program Confer Policy. The agencies share information and offer consultation on proposed State Plan Amendments, waiver proposals or amendments, demonstration project proposals or amendments, and rule-making that may have significant impact, specific, and/or disproportionate implications on Indian or Tribal Members of the Nine Federally Recognized Tribes in Oregon, or have implications on the Indian Health Services, tribal health programs or Urban Indian Health Program, or have a direct effect on one or more Tribes. Specifically changes that would impact eligibility determinations, changes that reduce payment rates or changes in payment methodologies, reductions in covered services, changes in provider qualifications/requirements, and proposals for demonstrations or waivers.
Process:
Pursuant to CMS's transparency regulations at 42 CFR 43l .408(b), State Medicaid Director Letter #01-024 and Section 8 of CMS's Tribal Consultation Policy, OHA must offer consultation with Tribes prior to submitting any Section 1115 and 1915 waiver request to CMS. OHA must offer consultation with Tribes at least sixty (60) calendar days before OHA intends to submit a Medicaid waiver request or waiver renewal to CMS. The Dear Tribal Leader Letter (DTLL) or notification required by SMD #01-024 must describe the purpose of the waiver or renewal and its anticipated impact on Indians/Tribal Members/Tribes. For Tribes to understand the impact on its tribal members, the notification should include the actual language from the demonstration waiver or renewal that has tribal implications and should not be in summary or outline form. Upon the determination of the consultation mechanism, proper notice of the Critical Event and the consultation mechanism utilized shall be communicated to affected/potentially affected Tribes using all appropriate methods including mailing and broadcast e-mail. Such notice shall be provided to:
a. Tribal Chairman or Chief and their designated representative(s)
b. Tribal Health Clinic Executive Directors of Oregon's 638/FQHC providers
c. IHS Clinic(s) Executive Director
d. Tribal Organization(s) Health Director and/or designated representative(s)
e. Tribal Organizations established to partner with IHS and Tribal health programs and such as the Northwest Portland Area Indian Health Board Executive Director or designee(s)
f. UIHP Executive Director or designee(s)
g. Tribal General Manager
h. Tribal Human Services, Social Services, or Vocational Rehabilitation Directors and/or designated representative(s)
Tribal notification occurred on TBD and concluded TBD. Tribes were notified using the method described above. No comments were received. The public notice period commenced on TBD and was completed on TBD. Public notice was posted in electronic format here: UPDATE and to FlashAlert as described above. Public notice with a physical copy of the waiver application was posted in all local offices on the same day. INDICATE IF COMMENTS RECEIVED

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

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

7. Contact Person(s)

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) 945-5872

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: Knight-Coyle

First Name: Nakeshia

Title: Director, Aging and People with Disabilities

Agency: Oregon Department of Human Services

Address: 500 Summer St. NE, E-02

Address 2:

City: Salem

State: **Oregon**

Zip: 97301

Phone: (503) 507-9963 **Ext:** ☐ **TTY**

Fax: (503) 373-7823

E-mail: nakeshia.knight-coyle@odhs.oregon.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Oregon**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

None of the above changes apply. This is a waiver renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

one):

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Oregon Department of Human Services

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

Oregon Health Authority (OHA), the single state Medicaid Agency, and the Oregon Department of Human Services (ODHS), the Operating Agency, have an Intergovernmental Agreement (IGA) 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 maintain oversight of ODHS 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 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 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:
- 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 OHA for final approval.
- Waiver renewals, requests for amendments and 372 reports will be approved and submitted by OHA to CMS.
- Formal correspondence with CMS is submitted by OHA. Informal correspondence with CMS is copied to OHA.
The Oregon Health Authority has oversight responsibility for all Medicaid programs, including the following functions related to HCBS waivers:
- Annual review of waiver enrollment measured against enrollment projections.
- Annual review of waiver expenditures measured against expenditure projections.
- Utilization management- OHA will review expenditures to ensure compliance with relevant statutory and regulatory authority and administrative rules and policies.
- Qualified Provider Enrollment and Termination - OHA will review provider enrollment and termination procedures and policies to ensure that Medicaid providers meet documented provider qualifications.
- Execution of Medicaid Provider Agreements - OHA will provide oversight to assure that Medicaid agreements are executed appropriately. OHA will also directly execute Medicaid agreements with providers choosing to contract directly with OHA.
- Rules, Policies, and Procedures Governing the Waiver Program- OHA will assist in the development, implementation and oversight of rules, policies and procedures governing the waiver program.
- Quality Assurance and Quality Improvement Activities - OHA will review ODHS' waiver assurances and standards of quality and remediation activities.
The IGA formalizes OHA oversight here -
3.1 PROGRAM RELATED OVERSIGHT

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

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

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

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

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

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

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

Within the OHA/ODHS Inter-agency Agreement, Schedule C, OHA has designated ODHS as an Organized Health Care Delivery System (OHCDS), as defined in 42 CFR 447.10(b). As such, ODHS may contract with or enter into provider enrollment agreements, inter-agency agreements, grants or other similar arrangements with qualified individuals, entities or units of government to furnish Medicaid/CHIP administrative or programmatic services for which ODHS has responsibility. The agencies renew this agreement every two years. For this waiver, ODHS contracts with local Area Agencies on Aging, willing Tribes, and service providers. OHA retains ultimate administrative authority, while ODHS is responsible for the operations of the waiver.

○ **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:

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

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

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

Appendix A: Waiver Administration and Operation

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:

OHA will exercise oversight of Medicaid/CHIP programs by participating in related committees and approving ODHS reports and documents as necessary. Each year, OHA will review and approve annual CMS 372 waiver reports for each waiver, reports of quality assurance performance outcomes across the spectrum of Medicaid state plan and waiver services offered, and reports of Medicaid policy changes planned in the near and long-term. OHA will review ODHS quality control processes for Medicaid/CHIP programs managed by ODHS to assure proper oversight of central office and local operations. This will include an initial review of program oversight activities during the first two years of this agreement and a follow up review during subsequent three-year periods thereafter. OHA will designate internal staff to review the processes employed, and outcomes reported, by ODHS in order to ensure prompt and accurate level of care determination, participant access to qualified providers, person-centered service planning/delivery, enforcement of safeguards that ensure participant health and safety, and maintenance of financial accountability for all home and community-based waiver service levels.

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

In a two-year cycle, the 1915 Waiver QA staff conduct a local review, evaluating activities in all local ODHS, AAA, and Oregon Tribal/NARA offices against waiver requirements such as timeliness, accuracy, appropriateness of services, services billed are actually received, compliance with State and Federal regulation, program outcomes, consumer satisfaction and cost effectiveness. The process of evaluation involves 1915 Waiver QA staff examination of a valid sample of participant cases through review of data stored in electronic databases, review of case files on-site, and individual interviews that include an assessment of consumer satisfaction. The 1915 Waiver QA staff record findings using a standardized tool and issues a formal finding in a report to the local office identifying trends in policy and rule application. At this time a 45 day period begins for the local office to make case specific corrections. The 1915 Waiver QA staff review corrections to determine completeness. A final report is provided to the local office, summarizing findings. The local office must submit a plan of correction to ODHS within 14 days of receipt of this report that addresses any issues found in the 1915 Waiver QA staff report. Once the Corrective Action Plan is received from the local office and accepted, APD Central Office follows up on the plan to ensure compliance and remediation of any issues addressed. This process is a source of ongoing data about assistance with waiver enrollment, LOC activities, participant services plans, and prior authorization of waiver services. The process also provides information, through direct observation and review of factors associated with participant outcomes and satisfaction, that aids evaluation of other functions such as dissemination of information concerning the waiver to potential enrollees, recruitment of providers, utilization management and training/technical assistance concerning waiver assurances.

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

The Medicaid/Chip Operations Coordination Steering Committee (MOCSC) is an internal leadership and governance body of OHA and ODHS, chartered in accordance with the IAA. MOCSC is co-chaired by representatives of OHA and ODHS appointed by the OHA/ODHS Joint Operations Steering Committee (JOSC). The MOCSC provides high level oversight and decision-making on the operations of the Medicaid/CHIP programs and monitors the inter-agency agreements between ODHS and OHA about Medicaid/CHIP program operations and their administrative issues.

Roles of the MOCSC include, but are not limited to:

- Providing high level oversight and decision-making on the operations of the Medicaid/CHIP programs;
- Ensuring the objectives of the inter-agency agreements between ODHS and OHA about Medicaid/CHIP program operations and their administrative issues are being met;
- Ensuring that members fully discuss Medicaid/CHIP business and fiscal and operations issues that require decisions and resolution;
- Providing a high-level forum for the regular exchange of information on Medicaid/CHIP operations.
- Providing recommendations to the JOSC or the Medicaid/CHIP Policy Steering Committee/Joint Policy Steering Committee (JPSC) that link the business objectives of OHA and ODHS (and the joint administrative processes applicable to Medicaid/CHIP programs operational and business processes) and may significantly affect both agencies; and
- Providing timely access, as needed by committees or work groups, to review and recommend necessary actions, including an expedited review and decision-making process to accommodate time lines.
- Referring concerns or disagreements related to decisions by the MOCSC to JOSC or JPSC as appropriate.

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7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities

that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* 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	Local Non-State 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	☒	☒	☐	☐
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:
PM9:The percent of AAAs/Tribal Case Management Entities that need on-site monitoring or technical assistance that receive on-site monitoring or technical assistance. N: The number of AAAs/Tribal Case Management Entities who received on-site monitoring or technical assistance. D: The number of AAAs/Tribal Case Management Entities 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**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Biennially

Performance Measure:
PM2:Percentage of aggregated performance measure reports, trends, and remediation efforts reviewed by OHA. N: Number of aggregated performance measure reports,trends, and remediation efforts reviewed by OHA. D: Number of aggregated performance measure reports, trends, and remediation efforts generated by 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:Number and percent of annual aggregate waiver expenditures that remain cost neutral N = Number of waiver years that remain cost neutral D = Number of waiver years reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM4: The number and percent of Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) meetings held between the operating agency (OA) and the SMA per year (MOCSC meeting agendas cover 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**

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:

Performance Measure:
PM1:Percentage of oversight of waiver amendments, renewals and financial reports. N: Number of waiver amendments, renewals and financial reports approved by OHA prior to implementation. D: Number of waiver amendments, renewals and financial reports provided by 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:
PM3:The number and percent of waiver amendments reviewed with Oregon's Tribal partners prior to submission to CMS N = Number of waiver amendments reviewed with Oregon's Tribal partners prior to submission to CMS D = Number of waiver amendments submitted to CMS.

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

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

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

Data Aggregation and Analysis:

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

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. OHA reviews 100% of ODHS submissions of waiver renewals, amendments, required reports, and required committee meetings related to the operation of Medicaid programs by the operating agency. Upon completion of OHA's analysis and review of ODHS' quality assurance data and reports, all relevant information 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 documents 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.

The 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.

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 local 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 OHA and/or ODHS Quality Management Staff to determine that the corrective action was successfully completed by the local 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 (AAA, Oregon Tribes, 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 14 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 once the plan is accepted or within 30 days.

Completion of corrective actions: Within 6 months, unless additional time is needed because of training availability.

OHA timelines for remediation:

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

Corrective Actions, including training and revision of administrative processes and procedures: Begin process within 30 days of OHA's approval of ODHS'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 60 day tribal input period and 30 day public input period, as well as the 90 day approval process.
Follow-up to determine effectiveness of remediation activities will occur during Corrective Action Plan check-ins and 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. 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 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					
	☒	Aged	65		☒
	☒	Disabled (Physical)	18	64	
	☐	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			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Not applicable.

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:

Not applicable.

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	50227
Year 2	

Waiver Year	Unduplicated Number of Participants
	53743
Year 3	57504
Year 4	61530
Year 5	65837

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:

ODHS offers entry to the waiver to all persons in the target populations that meet financial criteria, meet criteria for *nursing facility level of care defined as* Service Priority Levels 1-13, (specified in Oregon Administrative Rules (OAR 411.015.0000 - 0100), and do not otherwise have natural supports available to meet assessed needs. ODHS determines Service Priority Levels based on needs for assistance in activities of daily living as assessed using the standardized Client Assessment and Planning System (CAPS). This assessment documents a person's abilities and limitations in areas of activities of daily living (ADL) and instrumental activities of daily living (IADL). It also collects information about living environments, personal characteristics and preferences, treatments and general health history. The tool also documents any natural supports available to meet any assessed needs of the participant. Natural supports are assigned tasks that are mutually agreed upon by the waiver participant and the person providing the natural support. Using a programmed algorithm, CAPS then calculates an individual's priority for receiving services based upon the degree of assistance an applicant requires with specific activities of daily living. This assessment tool is used to determine level of care for both home and community-based care and nursing facility care.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ( ) **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 mandatory and optional SSI related group covered under the State Medicaid plan. Each group covered is below.

- 42 CFR 435.120- Aged, Blind and Disabled Individuals Receiving Cash Assistance- Individuals receiving SSI
- 1902(a)(10)(A)(i)(II) and 1905(q)- Qualified severely impaired blind and disabled individuals under age 65
- 42 CFR 435.130 Individuals receiving mandatory State-supplements.
- 42 CFR 435.131 Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance.
- 42 CFR 435.133 Blind and disabled individuals who--
a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and
b. Were eligible for Medicaid in December 1973 as blind or disabled; and
c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.
- 42 C F.R. 435.134- Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972) who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.
- 42 CFR 435.10- Mandatory categorically needy, other required special groups, and specified optional groups.

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:

For waiver participants living in their own homes, the needs allowance is equal to the individual's total income.

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

○ **Other**

Specify:

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

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in 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.

For waiver participants living in their own homes, the needs allowance is equal to the individual's total income.

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

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR § 435.726 or 42 CFR § 435.735,

explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

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

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR § 441.303(c)(1), specify the

educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

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

ODHS minimum case manager qualifications are:

Bachelors degree in a Behavioral Science, Social Science, or a closely related field; OR

Bachelors degree in any field and one year of human services related experience (i.e., work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house); OR

Associates degree in a Behavioral Science, Social Science or a closely related field AND two years of human services related experience (i.e. work providing assistance to individuals and groups with issues such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate housing); OR

Three years of human services related experience (i.e., work providing assistance to individuals and groups with issues such as economically disadvantaged , employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate housing).

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

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

(1) Requires Full Assistance in Mobility, Eating, Elimination, and Cognition.
(2) Requires Full Assistance in Mobility, Eating, and Cognition.
(3) Requires Full Assistance in Mobility, or Cognition, or Eating.
(4) Requires Full Assistance in Elimination.
(5) Requires Substantial Assistance with Mobility, Assistance with Elimination and Assistance with Eating.
(6) Requires Substantial Assistance with Mobility and Assistance with Eating.
(7) Requires Substantial Assistance with Mobility and Assistance with Elimination.
(8) Requires Minimal Assistance with Mobility and Assistance with Eating and Elimination.
(9) Requires Assistance with Eating and Elimination.
(10) Requires Substantial Assistance with Mobility.
(11) Requires Minimal Assistance with Mobility and Assistance with Elimination.
(12) Requires Minimal Assistance with Mobility and Assistance with Eating.
(13) Requires Assistance with Elimination.

Definitions of levels of assistance:
Independent: The individual does not meet the definition of "Assist" or "Full Assist".

Assist: Even with assistive devices, the individual requires assistance from another person with a task of the ADL at least one day each week totaling four days per month during the assessment timeframe. For Cognition, this means the individual either needs substantial assistance in one of the four components of cognition or needs minimal assistance in at least two of the four components of cognition.

Full Assist: Even with assistive devices, the individual is unable to accomplish any task of the ADL without the assistance of another person. This means the individual needs hands-on assistance of another person through all tasks of the activity, every time the activity is attempted. For Cognition, this means the individual either needs full assistance in at least one of the four components of cognition or substantial assistance in at least two of the four components of cognition.

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

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

Levels of Care are determined as a result of a comprehensive assessment, conducted by a case manager, using an electronic tool called the Client Assessment and Planning System (CAPS). This assessment documents a persons abilities and limitations in areas of activities of daily living (ADL) and instrumental activities of daily living (IADL). It also collects information about living environments, personal characteristics and preferences, treatments and general health history. Using a programmed algorithm, CAPS then calculates an individuals priority for receiving services based upon the indication of the need to receive Nursing Facility level of services within the next 30 days and absent the receipt of services the person would be institutionalized due to their need. This assessment tool is used to determine Level of Care for both home and community-based care and nursing facility care.

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

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

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

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

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

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

Tribal case managers do not conduct level of care assessments or reassessments.

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):*

ODHS sends each ODHS/AAA/Oregon Tribe/NARA office a computerized list of names of individuals who must have an annual re-assessment within the next 90 days. The list includes case manager identification.

Level of Care Re-assessments must be done by the CAPS review due date or ODHS will suspend payment for individual and facility providers. Overdue assessments may be viewed by either running the report "SJC2080R-A" in View Direct or viewing the "CAPS Assessments Past Due" report that is provided by the Office of Reporting, Research, Analytics and Implementation.

APD auto-issues a notification to individuals when it is a time for a re-assessment. The notification is sent 45 days prior to a required LOC re-assessment. The case manager contacts the individual to schedule the evaluation/reevaluation of LOC. The individual can also contact the case manager directly at any time to schedule an evaluation/reevaluation.

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

Tribal entities do not provide reevaluations of Level of Care.

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

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%/10%/50% for all ODHS-operated offices
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(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 = 95%/10%/50% for all AAA offices
☐ **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**
☐ **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.

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

Performance Measures

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

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

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

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

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

		95%/10%/50% of all AAA offices
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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%/10%/50% for all ODHS-operated offices.
☐ **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.

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

Performance Measures

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

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

Performance Measure:
PM12: Number and percent of LOC that were completed based on the instruments

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/10%/50% for all AAA offices.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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%/10%/50% for all ODHS operated offices.
☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☒ **Other** Specify: Biennially.

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

Data and reports gathered and created by 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. Designated staff within
ODHS will review a representative sample of individual files case managed by ODHS-operated local offices using a 95%/10%/50% method. The method is per ODHS/AAA office and results in a larger sample size than a statewide 95%/5%/50% method. Upon completion of OHA's analysis and review of ODHS' quality assurance data and reports, all relevant information 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.
The 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.
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 local 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 OHA and/or ODHS Quality Management Staff to determine that the corrective action was successfully completed by the local 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 (AAA, Oregon Tribes, 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 14 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 once the plan is accepted or within 30 days.

Completion of corrective actions: Within 6 months, unless additional time is needed because of training availability.
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 60 day tribal input period and 30 day public input period, as well as the 90 day approval process.
Follow-up to determine effectiveness of remediation activities will occur during Corrective Action Plan check-ins and 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. 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: Biennially.

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

ODHS assures that individuals who are eligible for services under the waiver will be informed of feasible alternatives for long-term care and given a choice as to which type of service to receive. When an individual is determined to require the Level of Care provided in a Nursing Facility, the individual or his or her legal representative will be:

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

Case managers document the offer of choice on the choice form. The offer of choice is given before an individual is enrolled onto the waiver. 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.

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Language assistance is available for telephone conversations through a contractor.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Waiver Case Management		
Other Service	Housing Support Services		
Other Service	Transition Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Waiver Case Management services are furnished to assist individuals in gaining access to needed medical, social, educational and other services. At a minimum, case management must include quarterly direct contact with the individual waiver participant and, during the other months, monthly monitoring which will, at a minimum, include the review of

records and encounter data to ensure that needed services are provided in accordance with the individual's person-centered service plan and that there is no need to update/alter the plan.
Case management services are provided by ODHS, AAA and Tribal case management entities. ODHS and AAA case managers provide all case management tasks, including initial and annual assessments/reassessments. Tribal entities provide periodic, ongoing assessments/reassessments, service plan development, referral and related activities, and monitoring and follow-up activities.

Waiver Case Management includes the following assistance:
*~ Initial assessment and annual reassessment of individual needs
*~ Periodic, ongoing reassessment of individual needs

Initial assessment, annual reassessment and periodic, ongoing assessment activities include:
• Taking the individual's history;
• Evaluation of the extent and nature of recipient's needs (medical, social, educational, and other services) and completing related documentation;
• Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

* Initial and annual reassessment activities also include Level of Care evaluation/reevaluation and monitoring for compliance with HCBS settings criteria (OAR 411-004 series).*

Tribal entities conduct ongoing, periodic reassessments, but do not conduct initial or annual reassessments. Initial and annual reassessments also include a level of care reassessment and cannot be conducted by tribal entities due to the eligibility component.

~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 person-centered care plan is implemented and adequately addressing the individual's needs. The activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary to assure following conditions are met:
• Services are being furnished in accordance with the individual's person-centered care plan;
• Services in the care plan are adequate; and
• If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

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

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

(i) The name of the individual;
(ii) The dates of the case management services;
(iii)The name of the provider agency (if relevant) and the person providing the case management service;

(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services;
(viii) A timeline for reevaluation of the plan.

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

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

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

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 Manager

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Waiver Case Management

Provider Category:
Agency
Provider Type:
Case Manager

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Employees of agencies authorized through the 1915(b)(4) APD Case Management waiver to provide case management services.
Agencies include Oregon Department of Human Services (ODHS), local Area Agencies on Aging (AAA) offices and Oregon Tribes.

Minimum qualifications for case managers:

Bachelor's degree in a Behavioral Science, Social Science, or a closely related field; OR

Bachelor's degree in any field and one year of human services related experience (i.e., work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house); OR

Associates degree in a Behavioral Science, Social Science or a closely related field AND two years of human services related experience (i.e. work providing assistance to individuals and groups with issues such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate housing); OR

Three years of human services related experience (i.e., work providing assistance to individuals and groups with issues such as economically disadvantaged , employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate housing).

Case managers must also pass a criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local ODHS/AAA/Oregon Tribe/NARA offices ensure minimum qualifications are met prior to employment.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Housing Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Housing Support Services provide necessary supports for an individual to obtain and reside in an independent community setting and are tailored to the goal of maintaining an individual's personal health and welfare in a home and community-based setting. These services are:
o Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers.
o Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.
o Assisting with the housing application process. Assisting with the housing search process.
o Identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses.
o Ensuring that the living environment is safe and ready for move-in.
o Assisting in arranging for and supporting the details of the move.
o Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.
Individual Housing & Tenancy Sustaining Services: This service is made available to support individuals to maintain tenancy once housing is secured. The availability of ongoing housing-related services in addition to other long-term services and supports promotes housing success, fosters community integration and inclusion, and develops natural support networks. These tenancy support services are:
o Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
o Education and training on the role, rights and responsibilities of the tenant and landlord.
o Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
o Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
o Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized.
o Assistance with the housing recertification process.
o Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

o Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

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

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

Not applicable

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	Housing Navigator

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Support Services

Provider Category:

Agency

Provider Type:

Housing Navigator

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Employees of agencies authorized through the 1915(b)(4) APD Case Management waiver to provide Housing Support Services.
Agencies include Oregon Department of Human Services (ODHS), local Area Agencies on Aging (AAA) offices and Oregon Tribes.

Minimum qualifications for Housing Navigators:

Six months of experience providing services to persons who are elderly or disabled; AND
training and experience which shows knowledge of at least four (4) of the areas listed:
- medical and psychosocial problems of the elderly and disabled.
- normal and abnormal human development and behavior.
- appropriate intervention methods for the elderly and disabled.

- medical terminology and procedures.
- implications of illness or injury upon clients and families.
- State and Federal rules about long-term care, medical services, and clients' rights.
- policies and procedures about agency programs.
- available community resources.
- crisis intervention, counseling, being an advocate, community relationships, and/or referral methods.

Housing Navigators must also pass a criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

Local ODHS/AAA/Oregon Tribe/NARA offices ensure minimum qualifications are met prior to employment.

Frequency of Verification:

At time of offer of employment and upon promotion of the Housing Navigator.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transition Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

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

Transition assistance payments will be limited to:
Moving and move-in costs including; movers, cleaning and security deposits, payment for background/credit check (related to housing), initial deposits for heating, lighting and phone; and payment of previous utility bills that may prevent the individual from receiving utility services, and basic household furnishing (i.e. bed) and other items necessary to re-establish a home. Necessary home accessibility adaptations must be made prior to the individual moving in to the in-home setting. Modifications over $500 must be completed by a state-licensed contractor. Any modification requiring a permit must be inspected and be certified as in compliance with local codes by local inspectors and filed in provider file prior to payment.

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

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

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

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

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**
☐ **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	In Home Care Agency (ORS 443.305)
Individual	General Business Provider
Agency	Home Health Agency (ORS 443.005)
Individual	Self-employed Registered Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Agency

Provider Type:

In Home Care Agency (ORS 443.305)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

APD/OHA initially and ongoing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Individual

Provider Type:

General Business Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Local AAA/ODHS office.

Frequency of Verification:

Prior to each purchase or payment for services.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Agency

Provider Type:

Home Health Agency (ORS 443.005)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

APD/OHA initially and ongoing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Individual

Provider Type:

Self-employed Registered Nurse

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

APD/OHA

Frequency of Verification:

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

Appendix C: Participant Services

C-1: 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:

The 1915(c) waiver is operated concurrently with a 1915(b)(4) waiver limiting freedom of choice case management providers to employees of ODHS, the local Area Agency on Aging, or Oregon Tribes. Case Managers receive training on the HCBS settings regulation and person-centered planning requirements through the OAR 411-004 series titled Home and Community-Based Services and Settings and Person-Centered Service Planning.

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.

Service
Waiver Case Management
Housing Support Services

1. Will any in-person visits be required?

- ○ **Yes.**
- ◉ **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

☒ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc.** ***Explain:***

All services are delivered in a way that respects the privacy of the individual. The services in the 1915(c) are not personal care services. For teleservices, the case manager will ensure that individual selects who else will be involved in the waivered case management services. Housing navigators will do the same.

☐ **How the telehealth service delivery will facilitate community integration.** ***Explain:***

Not applicable.

☐ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual.** ***Explain:***

Not applicable. These are not personal care services. Waivered case management and housing support services are easily managed remotely at the request of the individual.

☒ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.** ***Explain:***

These are usually conducted via telephone. If a telephone is not available, an in-person contact will occur.

☒ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

Remote telehealth provides more timely access to case managers and housing support services. It allows individuals to more quickly access needed services and make changes to their services plans.

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) and (c) Positions subject to required criminal history and background investigations. Oregon Revised Statute (ORS) 181.537 and OAR 410-007-0200 through 0370 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 provide services to vulnerable people.

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

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

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

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

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

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

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

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

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

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

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).

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):

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

b) Abuse screenings are conducted on Subject Individuals (SIs), including the following-
- An individual who is licensed, certified, registered, or otherwise regulated or authorized for payment by the Department or Authority and who provides care.
- An employee, contractor, temporary worker, or volunteer who provides care or has access to clients, client information, or client funds within or on behalf of any entity or agency licensed, certified, registered, or otherwise regulated by the Department or Authority.
- Any individual who is paid directly or indirectly with public funds who has or will have contact with recipients of:
  (i) Services within an adult foster home (defined in ORS 29 443.705); or
  (ii) Services within a residential facility (defined in ORS 31 443.400)
- Any individual who works in a facility and provides care or has access to clients, client information, or client funds secured by any residential care or assisted living facility through the services of a personnel services or staffing agency.
- Any individual who works in a facility and provides care, or has access to clients, client information, or client funds secured by any nursing facility through the services of a personnel services or staffing agency.
- an individual who lives in a facility that is licensed, certified, registered, or otherwise regulated by the Department to provide care. The position of this SI includes but is not limited to resident manager, household member, or boarder.
- A homecare worker as defined in ORS 410.600, a personal support worker as defined in ORS 410.600, a personal care services provider, or an independent provider employed by a Department or Authority client who provides care to the client if the Department or Authority helps pay for the services.
- An employee providing care to clients of the Department's Aging and People with Disabilities (APD) programs who works for an in-home care agency as defined by ORS 443.305 which has a contract with the Department's APD programs.
- Any individual who is required to complete a background check pursuant to Department or Authority program rules or a contract with the Department or Authority, if the requirement is within the Department or Authority's statutory authority.

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

d) For a waiver participant whose service provider was added to the abuse registry, the case manager works to offer the individual choice in another provider.

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: Facility Specifications

Facility Type:

Adult Foster Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Housing Support Services	☒
Waiver Case Management	☒
Transition Services	☒

Facility Capacity Limit:

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

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Housing Support Services	☒
Waiver Case Management	☒

Waiver Service	Provided in Facility
Transition Services	☒

Facility Capacity Limit:

none

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☐
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

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

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

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

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

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Care Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Housing Support Services	☒
Waiver Case Management	☒
Transition Services	☒

Facility Capacity Limit:

none

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

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

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

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law 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 may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

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

- ( ) **Other policy.**

  Specify:

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

Provider enrollment for case managers and Housing Navigators is restricted through the 1915(b)(4) waiver. Qualified case managers and Housing Navigators must be employees of ODHS, a AAA office or Oregon Tribe/NARA authorized under the 1915(b)(4) waiver to provide case management and Housing Support Services. Provider enrollment for Transition Services is based on Provider type and can be found in section C-1/C-3: Provider Specifications for Service. For general business providers of community transition services, as with other listed community transition services' providers, APD has open enrollment. Providers may also enroll through OHA. To ensure all willing and qualified general business providers have the opportunity to enroll, both ODHS and OHA maintain information on the internet at https://www.oregon.gov/dhs/PROVIDERS-PARTNERS/Pages/index.aspx or https://www.oregon.gov/oha/hsd/ohp/pages/provider-enroll.aspx. These sites maintain information about: requirements to qualify, enrollment, how payment is rendered, and contact information. The local AAA/ODHS offices are also available to provide information. For general business providers to learn if they are qualified, the timeframe can be as short as one business day if all needed information is received. Once qualified, enrollment is within five business days.

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.**

(a) Waiver case management may be provided in an acute care hospital setting as long as there is no duplication of services.

(b) The case manager will work to transition the individual back to the community by ensuring services and supports are in place.

(c) There is no difference in the billed rate for these HCBS provided during a hospitalization.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
PM13: Number and percent of provider applicants who obtain the appropriate certification, licensure and/or endorsement prior to rendering waiver services N: Number of provider applicants who obtained the appropriate certification, licensure and/or endorsement prior to rendering waiver services D: Total number of provider applicants who rendered provider services

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

number of enrolled non-licensed/non-certified providers reviewed

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

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

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:

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

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

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:

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

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

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

Performance Measure:
PM16: Not applicable. Service providers (case managers)under this waiver have no training requirements.

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: N/A	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: N/A
	☒ **Other** Specify: N/A	

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

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. ODHS reviews 100% of enrolled non-licensed/non-certified providers who adhere to waive requirements. Upon completion of OHA's analysis and review of ODHS' quality assurance data and reports, all relevant information 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 documents 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.

The 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.

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 local 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 OHA and/or ODHS Quality Management Staff to determine that the corrective action was successfully completed by the local 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 (AAA, Oregon Tribes, 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 14 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 once the plan is accepted or within 30 days.
Completion of corrective actions: Within 6 months, unless additional time is needed because of training availability.
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 60 day tribal input period and 30 day public input period, as well as the 90 day approval process.
Follow-up to determine effectiveness of remediation activities will occur during Corrective Action Plan check-ins and 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. 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: Biennially.

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design

methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

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.)*

HCBS is received in home and community-based settings. Community-based settings include Adult Foster Homes, Assisted Living Facilities, and Residential Care Facilities as described in Appendix C: Participant Services, C-2: Facility Specifications.

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 monitor for HCBS compliance in all settings where an individual receives waiver services. Monitoring occurs at least annually. Case managers received training on the OAR 411-004 series titled Home and Community Based Services and Settings and Person-Centered Service Planning for compliance monitoring.

Following initial on-site reviews, Residential Care Facilities and Assisted Living Facilities are formally reviewed for license renewal every two years. Adult Foster Homes are formally reviewed for license renewal annually. All contracted settings are routinely visited by case managers. Many facilities have Long-Term Care Ombudsman volunteers assigned, or one could be assigned, if a setting is determined to need additional oversight.

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:

Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. 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) Supports and information made available to the individual (and/or family or legal representative, as appropriate):

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

Case managers usually provide this information through discussions with individuals but also direct individuals to web resources and printed materials. Examples of web resources include-
-Aging and Disability Resource Connection of Oregon (ADRC) https://www.adrcoforegon.org/consumersite/index.php
-Oregon Consumer Guide to Assisted Living Facilities and Residential Care Facilities and A Guide to Oregon Adult Foster Homes https://adrcoforegon.org/consite/explore-in-a-facility.php
-Oregon Home Care Worker Registry https://www.carina.org/homecare/medicaid/oregon/

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

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

(b) Participant's authority to determine who is included in the process:

The individual or legal representative ultimately decides who may or may not be included in plan development discussions and contribute to the individual's service plan. Participants have the right to have anyone they choose present at any assessment. Case managers will assist the individual in selecting and notifying other participants in the assessment and planning process. ODHS also assists the process by issuing electronic notification 45 days in advance of the due date for annual LOC re-assessment and review of the service plan so that there is time to notify and prepare other participants.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. 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) Who develops the plan, who participates in the process, and what is the timing of the plan?

Case managers meet with each individual (and family or legal representative, as appropriate) at a schedule that will complete eligibility determination and an initial service plan within 45 days of request for services. The case manager contacts the individual within appropriate time frames to ensure there is no interruption of services. The individual then determines the time and location, as well as identifies the people that the individual wants present at the service planning meeting.
Case managers will meet again with the individual (and family or legal representative, as appropriate) at least annually to review the service plan. Other persons, as requested by the individual (or legal representative), may contribute to the assessment and development of this plan as well. If the individual chooses, service providers may also be included in both the assessment of needs and the plan development.

All individuals who receive home and community-based services must have an individualized person-centered service plan developed annually and updated as needed. Each plan includes the type of service to be provided, the authority under which the service is provided, the amount, frequency and duration of each service, the type of provider to furnish each service and the person responsible for carrying out the service. Since the plan is built in conjunction with the assessment of needs, it may be developed simultaneously with determination of level of care and eligibility for waiver services. The service plan may be developed shortly thereafter if the participant needs more time to consider service options or research available options as necessary. In addition, plans are flexible and change to address emerging participant needs and preferences.

(b) What types of assessments are conducted to support the service plan development process, including information about participant needs, preferences and goals, and health status?

Case managers conduct an assessment using the CAPS tool, which prompts the case manager to have a comprehensive discussion with the participant about the participant's functional abilities and strengths in completing activities of daily living and instrumental activities of daily living. Case managers must inquire and identify risks such as environmental hazards that may jeopardize safety or health. For participants living at home or in some foster homes, their own or family home, case managers gather information about emergency plans in the event of a natural disaster.

If health concerns come to the case manager's attention through observation or discussion, the case manager assists the individual to access health services or necessary medical supplies. Case managers may also refer participants for Long-term Care Community Nursing Services (LTCCNS), including delegation of some nursing tasks and teaching, training and monitoring on a variety of health-related topics. When a participant resides in a community-based care facility, the case manager will meet with the participant, review the facility service plan and meet with facility staff to gain information about participant service needs.

(c) How is the individual informed of services available under the waiver?

Case managers inform participants/legal representatives about service options at intake and when the individual is transitioning from a nursing facility. Participants/legal representatives indicate choice of either nursing facility or community-based care and their options of services provided through the waiver and state plan after receiving information about services. ODHS/AAA Case managers give initial applicants for services information about the wide array of options available to them, including services available under the State plan. These choices are explained again by the case manager whenever the participant's needs change significantly or when the participant/legal representative is considering changing service options. During plan development, once service needs have been recorded and summarized, service recipient/legal representative and case manager have another opportunity to review the services authorized and delivered and what types of supports are needed to meet the goals in the service plan. (See also D-1.c(a))

(d) How does the plan development process ensure that the service plan addresses the individual's goals, needs (including health care needs), and preferences?

CAPS has mandatory fields to be completed for ADL needs to determine eligibility. Each ADL and IADL has identified fields for preferences to be recorded regarding the individual's choice on how these services are to be provided. Additional preferences may be documents on each screen of the assessment in a comments section. CAPS

has a section to records the individual's goals as they relate to quality of life, health, and/or living situation as stated in the participant's own words.

(e) How are waiver and other services coordinated?

The case manager develops the person-centered plan with the participant/legal representative. The case manager discusses services available under waiver and State plan authority and discusses service options with the participant. After the plan is implemented, case managers communicate with participants and providers as needed to oversee the coordination of services. Case managers directly contact participants and providers by phone, mail, email, or in person within the care setting to address service delivery issues. Plan monitoring is the primary tool for the coordination of services.

Other factors in coordination of services are Oregon Administrative rules and policies that govern what service options may be combined. Some services may not be combined within the same plan as that combination would be considered a duplication of services (such as paying an In-Home Services provider while a participant resides in a facility). ODHS Central Office staff provide guidance to case managers through training and policy transmittals as to combination and duplication of services.

ODHS Central Office program specialists train case managers to identify existing social networks or natural supports (such as friends and family) and non-Medicaid community programs, services and resources such as Older American Act services) in the service plan. Case managers provide information and/or assist participants to access these services and coordinate these resources with the rest of the plan. Case managers use CAPS to document use of other resources in the service plan to promote the optimal coordination of services.

Case managers, coordinate services for individuals who reside in community-based facilities in cooperation with facility staff. The case manager communicates with staff and may participate in care conferences at the facility.

(f) How does the plan development process provide for the assignment of responsibilities to implement and monitor the plan? Case managers conduct plan monitoring to ensure authorized services are being provided. Means of monitoring vary slightly between the two major types of services:

For services provided to a recipient who lives at home, the case manager consults with the participant and provider to initiate service delivery, monitor for any change in care needs, and ensure the individual receives necessary supports. The case manager provides a task list for the individual and provider to use to self-monitor type and amount of services authorized. Provider Time Capture (PTC) allows Homecare Workers and Personal Care Attendants to electronically capture their time worked in real time. To meet Electronic Visit Verification (EVV) requirements, the following must be captured: type of service, consumer receiving the service, provider giving the service, date of the service, location of the service, and time the service starts and ends. Once this information is captured and confirmed as an authorized service, payment can be authorized.

In residential facilities, a facility service plan is developed with the individual and/or their representative and any persons the individual chooses, and includes all of the services agreed upon in the service plan. The individual and the provider both sign the plan and receive copies of the signed plan. The purpose of the facility service plan is to document the frequency and manner in which the individual's needs will be met. The facility service plan does not supersede the Medicaid waiver service plan and does not authorize payment for any Medicaid services. Facility service plans are reviewed at least annually by the case manager to ensure that the service plan meet's the individual's needs and preferences, and reflects the waiver service plan.

Plans for recipients receiving services in their own homes and in adult foster homes may specify monitoring of participant care by a Registered Nurse under contract with ODHS if referred by the ODHS/AAA case manager. In addition to RN delegation, the Contract RN may provide health monitoring, consultation with the physician and teaching to the participant and care provider. They may also provide the delegation of nursing tasks to a care provider. The service plan identifies the service provider and the type and frequency of the services authorized by the case manager and agreed to by the individual.

The case manager assigned to the ongoing service case has the responsibility to document in CAPS any risks or potential risks to the individual's health and safety identified in the assessment. The case manager has the

responsibility to document monitoring activities related to identified or reported health and safety concerns.

(g) How and when is the plan updated, including when the participant's needs change?

Service plans are reassessed at least annually. Service plans are monitored prior to the annual reviews as the individual's needs change, as determined by the case manager during the assessment or upon request of the individual or their representative. The plan is updated at least annually and more frequently with changes in a service recipient's condition or living situation. Sometimes a case manager schedules an earlier reassessment review date when a service recipient's needs, condition or care setting is expected to change. The participant has the right to request changes in provider and living situation and a change in plan will be made as soon as an alternate provider or living situation can be obtained. The case manager updates CAPS with new information and a plan for meeting new or changing needs.

(h) The individual (and family or legal representative, as appropriate) is engaged in the planning process from the beginning. This process is described above and involves learning the individual's needs and wants. Engagement is ongoing. Service plans are monitored and reassessed and include the individual (and family or legal representative, as appropriate).

(i) Case managers have the responsibility for developing a person-centered service plan in accordance with the individual's choice of services to be provided. The case manager must address all of the met or unmet needs of the participant through the assessment and provide the participant and service provider(s) with a copy of the service plan for signature by all parties for the authorized services. When written signature is not possible, an alternative signature method may be used. The methods include the use of e-signatures that meet privacy and security requirements and email signatures. The case manager will consult with service providers to review and verify the appropriate services are being offered and performed.

Additionally, to the extent that person-centered service planning meetings/assessments are conducted remotely, the following are safeguards:

- The agent performing the assessment is independent and qualified 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.
- Any conditions that must be met for the assessment/meeting to be conducted remotely vs. in person.

ODHS relies on the CAPS electronic case management system and its electronic tool for collecting, storing and summarizing service recipient information for service plan development.

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.

During initial person-centered plan development and subsequent reviews, the individual's Case Manager conducts an assessment using the CAPS tool to review risk factors for health and protective services with the individual, to offer resources to the individual and to plan appropriate safeguards. During the service planning process, the individual and/or their representatives discuss risk factors and back- up plans. The individual's service plan is developed and information regarding risk and back-up plans is incorporated into the person-centered plan. There is a section in the CAPS tool that incorporates identified risks and back-up plans. This information is part of the assessment summary section of the service plan.

For in-home consumers, case managers use a risk assessment and monitoring instrument, in conjunction with face-to-face CA/PS evaluations, to evaluate new participants and participants who have just experience significant changes. Risk is ranked as follows:

High Risk - An identified concern, that without mitigation, is likely to cause the individual to experience substantial injury or loss within the next 30 days, or the individual has experienced substantial harm within the previous 30 days and the harm will likely reoccur without mitigation.

Medium Risk - An identified concern, that without mitigation, is likely to cause the individual to experience minor injury or loss within the next 90 days or has experienced minor loss in the previous 30 days that will likely reoccur or worsen without mitigation.

Low Risk - An identified concern, that without mitigation, may result in harm. The risk of harm to the individual is not imminent nor likely to occur within 90 days, and/or harm has occurred within the last 30 days, has been mitigated, and is unlikely to reoccur within 90 days.

If the individual is assessed as a high or medium risk in any category, the case manager must work with the individual to develop a mitigation plan to help reduce the assessed level of risk. The plan must be documented, including the individual’s agreement to the plan, with any updates as needed. The individual may also choose to not participate in any mitigation plan, which also must be documented.

All risk assessments (even those with no high or medium risks identified) must document an agreed upon backup plan should a scheduled provider be suddenly unavailable. The backup plan must include the name and contact information of the backup individual, if applicable. Case managers are to document if an individual chooses to not have a backup plan or is unable to come up with one.

Risk Mitigation and Monitoring:
• If the individual is assessed as having at least one high-risk, the individual will need a monthly risk-focused mitigation/monitoring direct contact for any risks that have been identified.
• Otherwise, the individual will need quarterly risk-focused mitigation/monitoring (direct contact) for any medium or low risks that have been identified.

A Risk-Focused Mitigation/Monitoring Direct Contact must include the following actions from appropriate APD/AAA staff:
• Have a conversation with the individual to assess for new risks and to follow-up on previously assessed risk concerns, current mitigation plan (if one was required), and any other changes that might impact the individual’s assessed risk needs. A consumer or caregiver indicating everything is “fine” or “going well” does not constitute a risk assessment.
• Determine if the individual’s mitigation plan is being implemented (if one was required) to lower identified risk(s). Provide additional assistance as needed.
• Review the individual’s current back-up plan to ensure that the information is still current. This must be reviewed and documented, even if there is no assessed high or medium risk identified.
• Update current information on the individual’s risk concerns and mitigation/monitoring efforts in the risk assessment as needed.
• Provide case narration to indicate that a risk mitigation/monitoring direct contact is completed.

For individuals receiving services in a CBC, the facility is responsible for mitigating risk. APD/AAA staff may choose to complete a risk assessment; however, it is not required. APD/AAA staff should discuss with facility staff any identified risk concerns they are aware of that are not being addressed adequately.

If the case manager identifies risks to a recipient living at home or in a foster home, a referral to a Registered Nurse under contract with ODHS may be made to conduct a nursing assessment. The case manager may authorize follow-up visits. If appropriate, the RN develops a registered nurse plan of care for the participant and provider to follow, may delegate nursing tasks to the provider, and establish a monitoring schedule. Nursing delegation consists of training and observing that the provider is able to perform the task. The registered nurse must continue to monitor the performance of these delegated tasks and such monitoring must conform to Oregon Board of Nursing Standards.

The goals of community nursing care are to: maintain participants at to: maintain participants at functional level of wellness, minimize risk for participant, maximize the strengths of the participant and the care provider; and promote autonomy and self-management of health care through teaching and monitoring. For recipients living in community-based care facilities, the case manager will work with the facility staff and the facility nurse to address health concerns.

Vulnerability to Abuse. The case manager may identify other risks and will assess the individual's ability to make an informed decision. In those instances where the individual has the ability to make informed choices, the case manager will discuss alternatives which may mitigate the risk, may offer community resources and will document the individual's ability to make an informed decision. Individuals who demonstrate the lack of ability to understand the consequences of their decisions may be referred for protective services or guardianship services in the absence of legal representatives to assist with decision-making.

Back-up Care Providers: ODHS has alternate service providers such as Medicaid contracted in-home care agencies in some regions that an individual can employ on short notice if they cannot locate a Homecare Worker who can meets their needs. There are also other community-based settings such as adult foster care, adult day services, residential care and assisted living for an individual who needs immediate care services if the individual is unable to identify an Homecare Worker to employ. Currently the Oregon Home Care Commission, which maintains the centralized statewide registry of qualified homecare workers, as well as the local ODHS/AAA offices have lists of Homecare Workers enrolled in their specific regional service delivery areas.

For individuals with significant personal care needs, such as those with quadriplegia, case managers often assist with identifying a regularly-scheduled relief care provider as part of the service plan or have identified back-up providers or care setting alternatives as part of the service plan in case the participant's primary provider becomes ill or is suddenly no longer available. Individuals in community-based services always retain the option of transferring from one community-based setting to another or leaving waiver services to receive nursing facility services as their service needs warrant.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Participants are informed of the different waiver services, State plan services, settings and providers during the initial assessment and at each reassessment, or at the request of the individual.

The 1915 (b)(4) waiver restricts access to qualified case management providers to local ODHS, AAA offices, and willing Oregon Tribes/NARA.

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.
A. 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. 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 and the Medicaid/CHIP Operations Coordination Committee (MOCSC). The OHA/ODHS Liaison and the MOCSC reviews annual reports on key performance measures to ensure follow-up and compliance.
Case Managers who approve the Person-Centered Service Plan are employees of the State, AAAs or Oregon Tribes/NARA. The individual and/or their legal guardian and the Case Manager review and approve the Person-Centered Service Plan. The coordinator writes the plan based on the planning meeting and the individual and/or their legal guardian approves the written plan.
Appendix D performance measures include both a ODHS review of the person-centered service plan to ensure the plans are developed and implemented in accordance with the waiver.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, 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.

(a) (b) and (c) Case managers are responsible for the monitoring and implementation of the person-centered service plan and participant health and welfare. The monitoring and follow-up depends on a participant's needs and living situation. At a minimum, case management must include quarterly direct contact with the individual waiver participant, with in-person once a year at renewal. Case managers are required to monitor for the need of the service on a monthly basis.

Case managers monitor service plans monthly, and as often as is needed to ensure the appropriate delivery of waiver and State plan services to the individual. Monitoring includes the review of records and encounter data to ensure that needed services are provided in accordance with the individual's person-centered service plan and that there is no need to update/alter the plan. Monitoring through Contract RN contacts are documented and submitted to the case manager. Case managers use this documentation as a method of monitoring and will remediate any problems that are noted in the documentation.

Monitoring may also include a review of the person-centered service plan. This review consists of a determination of the adequacy of the services provided, whether services are provided in accordance with the current service plan, the individual has freely chosen the provider of services, back-up plan effectiveness, health and safety assurances and individual satisfaction with the services provided. This information is documented either in the CAPS tool, or in the case narrative, if a reassessment is not conducted at the time of the monitoring activities.

Remediation may consist of a reassessment of service needs and/or revision of the service plan. Results of monitoring are captured during the 1915 Waiver QA staff case reviews. Data gathered during the 1915 Waiver QA staff reviews are analyzed and remediation/corrective action requests are provided to the local offices for remediation/correction. Statewide remediation is done through training, policy transmittals and other methods of remediation, as required.

The case manager has the responsibility to document any risks or potential risks to individual health and safety identified in the CAPS assessment. The case manager has the responsibility to perform and document monitoring activities related to identified or reported health and safety concerns. Direct in-person contact is made at the request of the individual, representative or provider when there are changes in care needs, the plan is not sufficiently meeting the current care needs or the case manager determines that in-person contact is necessary in the individual's place of residence.

Monitoring also includes monitoring for risk mitigation as described in Appendix D-1-e.

b. Monitoring 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:
PM18: Number and percent of waiver participants whose service plans in which risks and safety factors are assessed N: Number of service plans which risks and safety factors are assessed D: Total number of service plans reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/10%/50% for all AAA offices
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

Data Source (Select one):
Other
If 'Other' is selected, specify:
CBC Settings risk and safety assessment

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):
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%/10%/50% for all ODHS-operated offices.
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		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

Performance Measure:
PM19: Number and percent of waiver participants whose service plans address personal goals and preferences N: Number of service plans in which personal goals and preferences are addressed D: Total number of service plans reviewed

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

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(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 = 95%/10%/50% for all ODHS-operated offices.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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%/10%/50% for all AAA offices
☐ **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

Performance Measure:

PM17: Number and percent of waiver participants whose service plans include services and supports that address assessed needs N: Number of waiver participants whose service plans include services and supports that address assessed needs D: Total number of waiver participants reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/10%/50% for all ODHS operated offices.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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 = 95%/10%/50% for all AAA offices
☐ **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.

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:
PM20: Number and percent of service plans that are completed according to the policies and procedures in the approved waiver N: Number of service plans that are completed according to the policies and procedures in the approved waiver D: Total number of service plans reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/10%/50% for all AAA offices

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

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%/10%/50% for all ODHS-operated offices
☐ **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

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:
PM21: Number and percent of waiver participants whose service plan was updated/revised every 12 months N: Number of service plans that were updated/revised every 12 months D: Total number of service plans reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/10%/50% for all ODHS-operated offices.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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%/10%/50% for all AAA offices
☐ **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

Performance Measure:
PM22: Number and percent of waiver participants whose service plan was revised, as needed to address changing needs N: Number of service plans revised, as needed to address changing needs. D: Total number of service plans reviewed in which revisions were necessary to reflect individuals change in needs.

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

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%/10%/50% for all AAA offices
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Biennially	

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%/10%/50% for all ODHS-operated offices
☐ **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

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:
PM23: Number and percent of waiver participants whose services are delivered in the type, scope, amount, duration and frequency in accordance with the service plan. N: *Number of authorizations that match claims for in-home and CBC* D: *Number of pay periods*

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:

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:
PM24: Number and percent of waiver participants who are offered the choice of institutional care and waiver services N: Number of waiver participants who are offered the choice of institutional care and waiver services D: Total number of waiver participants reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/10%/50% for all AAA offices
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify:	

	Biennially	

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%/10%/50% of all ODHS-operated offices.
☐ **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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/10%/50% for all AAA offices
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

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

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%/10%/50% for all ODHS-operated offices
☐ **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

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. Designated staff within
ODHS reviews 100% or a representative sample of individual files case managed by ODHS-operated local offices using a 95%/10%/50% method. The method is per ODHS/AAA office and results in a larger sample size than a statewide 95%/5%/50% method. Upon completion of OHA's analysis and review of ODHS' quality assurance data and reports, all relevant information 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 documents 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.
The 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.
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 local 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 OHA and/or ODHS Quality Management Staff to determine that the corrective action was successfully completed by the local 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 (AAA, Oregon Tribes, 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 14 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 once the plan is accepted or within 30 days.
Completion of corrective actions: Within 6 months, unless additional time is needed because of training availability.
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 60 day tribal input period and 30 day public input period, as well as the 90 day approval process.
Follow-up to determine effectiveness of remediation activities will occur during Corrective Action Plan check-ins and 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. 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**	☐ **Annually**

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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.

The case manager notifies the individual about the Fair Hearing process at any time a decision notice is issued and at least annually thereafter. During entrance to the waiver individuals are informed in writing in a decision notice that they have the right to appeal. The documentation explains how to appeal. The notice is sent by the Case Manager or directly by the IT systems. All decision notices include choice of services, choice of providers, and specific and detailed information regarding any denial, reduction, suspension, or termination of services.

As part of the notification of Fair Hearings procedure, the case manager informs the individual that continuation of services must be requested under the time frames specified in OAR 461-025-0310 and 461-25-0311. Individuals must request a hearing within 45 days of receiving the decision notice. Individuals may request a continuation of benefits pending the hearing decision if the request is made within 10 days of the decision notice and/or prior to the effective date of the action proposed in the notice.

The hearing request form informs the participant that the planned action described in the decision notice will take place on the effective date of the decision notice unless continuation of benefits is requested. The form contains a section that allows the participant to request that services continue during the period while the appeal is under consideration. If the participant requests to continue services, they mark the form accordingly. The default is that services do not continue unless requested. An active request is required to continue services.

Results of the hearing are provided to the individual in the form of a Hearing Order written by an Administrative Law Judge when the Office of Administrative Hearing (OAH) has final order authority. ODHS APD Director and Deputy Director have delegation to issue final orders and, in specific cases, revoke the final order authority of OAH. The Hearing Order is mailed to the individual.

ODHS has standardized forms and processes for informing individuals/legal representatives of rights, recording hearing requests, completing pre-hearing summaries, conducting hearings, and notifying individuals/legal representatives of the hearing outcomes. ODHS communicates additions or revisions to forms and processes to local ODHS/AAA offices through formal electronic transmittals.

Individual service recipients and applicants, and their legal representatives, are provided a timely written decision notice (DHS form 540 Notice of Planned Action and/or DHS form 2780N Service Plan and Notice) of any planned change in services or benefits, including denial, closure or reduction. The decision notice includes the reason for Dept.'s decision, administrative rules that support the decision and the individual's/legal representative's right to due process through an administrative hearing process.

Individuals/legal representatives who wish to contest the planned action complete and submit an Administrative Hearings Request (MSC form 443) to the local ODHS/AAA office. The local office can complete the MSC form 443 for the individual/legal representative's behalf when a verbal request for hearing is made. The local office forwards the Administrative Hearings Request to the ODHS Central Hearings Unit where it is assigned to a ODHS Hearing Representative. The Hearing Representatives are centralized and not part of any local office that determines benefits, services, or eligibility. The Hearing Representative reviews the notice sent to the participant to confirm adequacy and accuracy. If the Notice of Planned Action is insufficient or incorrect, the Hearing Representative contacts the local office to correct the decision notice or the ODHS Hearing Representative will amend the decision notice with another decision notice or an amended contested case notice. Amending the decision notice may or may not result in restoration of benefits until a corrected notice is provided to the participant. Individuals maintain the right to a continuation of benefits until a final order is issued. OAR 461-025-0311 details time frames for timely submission of a hearing request if a continuation of benefits is requested until a final order is issued.

The Hearing Representative conducts an informal conference with the individual/legal representative to provide the individual/legal representative the opportunity to questions the planned action and to present additional information if applicable. After the informal conference, one of four actions occur:

The individual/legal representative voluntarily withdraws the request for hearing;

ODHS withdraws the planned action;

The planned action is modified (in which case a new decision notice or amended contested case notice is sent to the individual/legal representative and the individual/legal representative once again has appeal rights); or

The contested case proceeds to hearing before an Administrative Law Judge.

If the individual/legal representative disagrees with the outcome of the contested case hearing before the Administrative Law Judge, the individual/legal representative may ask for a rehearing or reconsideration of the final order. The Individual/legal representative may also file with the Court of Appeals. If the individual/legal representative does not show for their scheduled hearing, the Administrative Law Judge may ask the Department to issue an Order of Dismissal.

ODHS Central Office, Direct Services, maintains a database updated by the ODHS Hearing Representatives that tracks each phase of the process and the outcomes(s) for each individual/legal representative who requests an administrative hearing.

Appendix F: Participant-Rights

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:

Anyone may file a grievance/complaint with the Governor's Advocacy Office (GAO) in the Office of the Director of the Oregon Department of Human Services. The local ODHS and AAA offices also have the responsibility to resolve any complaints that are brought to them. If the local office is unable to satisfactorily resolve the complaint, they may refer the person to the Governor's Advocacy Office.
The GAO receives and coordinates complaint resolution for clients of all ODHS related programs, including waiver participants and the general public. They collect relevant information from the party of interest and forward the request to the appropriate Central Office managers through controlled correspondence for resolution by phone/email. The GAO and the responding management work collaboratively to resolve the issue.
The GAO maintains a statewide database for any and all complaints related to ODHS & APD waiver participants.

- **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).

If an individual voices a concern or complains about an action that is adverse to them, APD will inform the individual of their hearing rights and ask if they would like to pursue this action.

Individuals are provided with a Rights and Responsibilities form that informs them of their hearing rights and are also given a form (DHS 9001) that provides them information regarding filing a complaint. These forms are provided at initial eligibility/intake and annually thereafter. The DHS 9001 provides the telephone number for the Governor's Advocacy Office (GAO), as well as information showing how to file a discrimination complaint. Complaints that are received at the local office may be resolved without being sent to the GAO and are not tracked for data gathering purposes.

Formal complaints or grievances relate to the individual's dissatisfaction with the provision of services or the performance of the local ODHS/AAA office or with ODHS Central Office. A formal grievance relates to a complaint about the way waiver services are being delivered or complaints about administrative process. Formal complaints or grievances can be received either in writing or verbally through either the local office or central office. The DHS 0170 form "Customer Service/Privacy Complaint or Report of Discrimination" should be made available in the lobby of ODHS branch offices and is also available on the GAO/ODHS website. https://www.oregon.gov/dhs/aboutdhs/pages/gao.aspx
All formal complaints/grievances are tracked by the GAO.
Informal complaints are complaints that do not rise to the level of dissatisfaction with provision of services, performance, service delivery or administrative process and are not tracked. These complaints are generally tied to personal preferences and are not related to the defined formal complaint/grievance process and are handled locally, usually by the case manager, or case management supervisor. These complaints are not tied to hearable issues or abuse reporting.

A letter of determination is optional if the individual is satisfied that the complaint has been resolved and states that they do not need a formal written response regarding the disposition of the complaint. The individual is informed by the case manager at the initial assessment and subsequent reassessments, and at the time the complaint is submitted if their complaint is a hearable issue. Written notification, including hearing rights and instructions for requesting a hearing, are provided at any time there is a reduction or termination of services.

If an individual does not agree with a recent determination to deny, reduce, or close a service or benefit, they have the right to appeal the decision. Hearing rights will be provided, and assistance given, to complete an Administrative Hearing Request Form (ODHS 0443) if requested. An individual may also submit a complaint to the GAO simultaneously, if desired.

a. There is no limitation on the types of complaints an individual may file.
b. The GAO logs the complaints into their tracking system.
c. The GAO contacts either ODHS central office staff or the local ODHS or AAA offices to research and help resolve the complaint. ODHS is able to get monthly reports on the types of complaints filed, the outcomes and who the complaint involves.

Process and Timelines:

If the participant uses the Client Complaint or Report of Discrimination Form (DHS 0170), the process for reporting discrimination may be found in Oregon Administrative Rule (OAR) 407-005-0030 and the procedure for formal complaints is outlined in 407-005-0010 - 407-005-0120:

1. If the local office receives, they must initiate the resolution process if it is a customer service complaint, only. The local office must also inform GAO of the steps for resolution and the outcome. If the complaint also includes concerns related to discrimination, those must be first sent to GAO to determine next steps. If the complaint is initially received by the GAO, the complaint is entered into the data base, then forwarded to the appropriate branch office or responsible program entity to initiate the resolution process.

2. If the compliant is Supplemental Nutrition Assistance Program (SNAP) related AND indicates concerns about discrimination, those are sent to GAO for review. If the complaint indicates concerns about discrimination related to age, those must be sent to USDA Food and Nutrition Services (FNS) within 5 business days. An individual does have the right to file a discrimination compliant directly with FNS. FNS conducts investigations independent of ODHS.

3. Within five business days of receiving this complaint from either an individual or from GAO, the participant must be contacted by the local program supervisor if it is a concern about customer service.

4. If it is a report of discrimination, the ODHS Civil Rights Investigator must contact the participant within 20 business days. The civil rights investigation will be conducted by the ODHS Central Office investigator, who will issue a letter of determination within 20 days following completion of investigation. Appropriate federal civil rights office will be notified.

5. Once contacted, an in-person or telephone meeting is to be conducted or scheduled with a manager and individual. If the complaint involves a ODHS employee, that employee has five business days to respond. Issues of complaint should be clarified and verified during the initial contact.

6. The complainant may involve a formal or informal support person/advocate at the meeting. If the complaint is regarding an employee, that employee may or may not be present in the meeting (i.e. participant does not want employee there or supervisor makes the call on it). The purpose of this meeting is to identify and address the complaint issues and resolution options.

7. Fact finding is conducted before participant contact, during the meeting session and following the meeting. A determination must be based on evidence. This may include interviews with internal and external parties, review of documentation and program policies, analyzing data and evidence gathered, determination of whether complaint is substantiated and consideration of the participant's willingness to resolve the complaint.

8. If the complaint is resolved, the local office is to complete the follow up form (DHS 0170A) for distribution to the GAO (mandatory) and the next level manager within five business days of the meeting. A letter of determination to the participant is optional---the decision is made on a case-by-case basis.

9. If the complaint is not resolved, it is referred to the next management level for review and follow-up. The GAO must be notified and provided documentation of initial meeting discussion and results within five business days of the meeting. Depending on the complaint, disposition of issue and evidence collected will influence the next steps in this process.

10. If the complaint cannot be resolved at the local office and service area levels, the complaint will be forwarded to GAO. The participant may pursue the grievance through the GAO or the appropriate federal program authority, including the court system.

11. Informal or verbal complaints are expected to be handled and resolved at the lowest level of intervention. If this is resolved locally, the GAO does not need to be notified. Any participant may pursue the grievance through the GAO, a higher ODHS authority, or the appropriate federal program authority.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines

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

Types of critical events or incidents

ODHS requires reports of critical incidents for any individual age 65 and older and adults with disabilities when circumstances involve observed or suspected abuse defined in Oregon Administrative Rule OAR Chapter 411 Division 020. Abuse required to be reported to Adult Protective Services (APS) includes Physical Abuse, Neglect, Abandonment, Verbal or Emotional Abuse, Financial Exploitation, Sexual Abuse, Involuntary Seclusion, and Wrongful Use of a Physical or Chemical Restraint that occur in in-home settings or licensed settings that are not federally-regulated Nursing Facilities. Self-neglect of an older adult or adult with physical disability is also reportable to APS for screening for a protective service response. Reports of critical incidents in Nursing Facilities, as well as reports of critical incidents in other APD-licensed facilities that do not rise to the level of abuse are reported to the ODHS Safety, Oversight, and Quality (SOQ) Unit.

ODHS APD developed a Serious Incident (SI) Team. The SI Team is able to analyze, track trends, triage, and report situations to case managers. The team is able to bridge gaps and support services when an adult protective service is screened out due to not meeting APS criteria, but meets serious incident criteria. The SI Team assists with the development of strategies to prevent or reduce further incidents from critical and serious incident referrals and reporting. Serious incidents are events that do not involve an APS, but are identified as meeting one of four major criteria. Specifically, death from an unknown cause and not related to the consumer's diagnosis, a missing person, emergency medical care, and unplanned hospitalization. Serious incidents are screened by APS and closed at intake due to not meeting APS criteria. ODHS APD committed to meeting CMS standards to minimize preventable incidents from reoccurring and developed the SI Team to provide proactive responses to reduce the risk and likelihood of future incidents. An incident management system was also implemented. The SI management system generates a daily report of all "Closed at Intake" APS calls from the prior day. The SI Team reviews each case for SI criteria, including narrative, hospital records, and Medicaid eligibility. The review is documented and the case manager is informed of the SI and provided preventative resources, if needed.

Appropriate authority

The Oregon Department of Human Services (ODHS) Aging and People with Disabilities (APD) program is responsible for protective services for adults, age 65 and older, and persons with disabilities in Oregon. These responsibilities extend to individuals receiving waiver and State plan services, private pay services, or no supportive services. General authority for adult protective services to older adults, age 65 and older, and persons with physical disabilities is in ORS 410. 020. Authority for investigations of abuse to adults, age 65 and older is provided in Oregon Revised Statutes (ORS) 124.070.

OHA delegates adult protective services for persons with intellectual/developmental disabilities or persons receiving behavioral services from an OHA program to the Office of Training, Investigations and Safety (OTIS). ODHS assigns adult protective services responsibilities for older adults and adults with physical disabilities to local ODHS and AAA offices, including taking reports of abuse (critical incidents) and providing the subsequent follow-up through screening, assessment, investigation, and provision of appropriate resources for victim safety.

Methods of reporting

Local ODHS and AAA offices and ODHS Central Office accept reports of critical incidents in any communication forms from mandatory reporters and anyone else who wants to report. Most reports are made by telephone with some reporting done by fax, letters, or e-mails. The local offices have specifically trained staff to record and respond to APS critical incident reports. The state office provides a statewide toll-free number to take reports. The state office and local offices offer translators, adaptive telephone technology, and alternative formats for reporting.

Some critical incidents may come to ODHS attention through the Long Term Care Ombudsman. The Office of Long Term Care Ombudsman is an independent state agency that serves long term care (including nursing facility, residential care, assisted living and foster home) residents through complaint investigation, resolution and advocacy for improvement in resident care. The Office includes the Governor-appointed State Ombudsman, ten full-time Deputy Ombudsmen, and a statewide network of volunteers. If the Ombudsman receives a complaint involving abuse it is referred to ODHS APS in compliance with federal law.

The Governor's Advocacy Office (GAO) is another means by which critical incidents may come to the attention of ODHS. This office is in the Director's Office and provides a central point of access for anyone having a problem with, or

seeking information about, the entire range of ODHS services. If the GAO receives a complaint involving ODHS services, GAO staff refer the complaint to the APD Central APS Unit for referral to the appropriate local office for APS screening and investigation.

Individuals required to report critical incidents and events:

Any person can report suspected or observed abuse incidents to ODHS including waiver participants, legal representatives and family. Any reporter has immunity for reports made in good faith for elder abuse.

For Residential Care Facilities and Assisted Living Facilities, the administration of the facility is required to report abuse. All employees who have reasonable cause to believe a resident has suffered abuse are responsible for reporting to appropriate facility personnel or to the Department. This responsibility is stated in OAR Chapter 411 Division 054 for Residential facilities and Assisted Living Facilities. If ODHS discovers through licensing survey, case manager onsite care monitoring, or complaint that an incident of abuse has not been reported, ODHS will investigate that circumstance as a rule violation.

ORS 124.060 mandates certain groups of persons to report elder abuse. Abuse mandated to be reported is defined under ORS 124.050 to be physical injury, neglect of care, abandonment, willful infliction of harm, sexual abuse, and financial abuse. ORS 124.050 (9) lists and defines the mandatory reporters to include:

(a) Physician or physician assistant licensed under ORS chapter 677, naturopathic physician or chiropractor, including any intern or resident.

(b) Licensed practical nurse, registered nurse, nurse practitioner, nurse's aide, home health aide or employee of an in-home health service.

(c) Employee of the Department of Human Services or community developmental disabilities program.

(d) Employee of the Oregon Health Authority, local health department or community mental health program.

(e) Peace officer.

(f) Member of the clergy.

(g) Regulated social worker.

(h) Physical, speech or occupational therapist.

(i) Senior center employee.

(j) Information and referral or outreach worker.

(k) Licensed professional counselor or licensed marriage and family therapist.

(L) Member of the Legislative Assembly.

(m) Firefighter or emergency medical services provider.

(n) Psychologist.

(o) Provider of adult foster care or an employee of the provider.

(p) Audiologist.

(q) Speech-language pathologist.

(r) Attorney.

(s) Dentist.

(t) Optometrist.

(u) Chiropractor.

(v) Personal support worker, as defined by rule adopted by the Home Care Commission.

(w) Home care worker, as defined in ORS 410.600.

(x) Referral agent, as defined in ORS 443.370.

Case managers and Adult Foster Care Licensors are mandatory reporters for elderly persons, age 65 or older of critical events or incidents as defined in ORS 124.050. ODHS strongly encourages reporting of critical events or incidents for individuals with disabilities under the age of 65.

Timeline for Reporting.

ODHS expects reports to be submitted as soon as abuse or self-neglect of an older adult, an adult with physical disabilities, or a resident of a licensed care facility is observed or suspected. In facilities, SOQ's Abuse Reporting and Investigation Guide for Providers defines immediate reporting as "The facility must immediately investigate injuries of unknown cause and report those incidents if abuse cannot be ruled out. It is expected that a determination about injuries of unknown cause can be made within 24 hours of the incident and if abuse can not be ruled out, the incident has been reported within that time frame." All community-based care providers are required to complete a provider orientation that provides them with this information.

ODHS staff use the Report of Serious Event (ROSE) form (APD 0307), which is designed to alert Central Office managers when there is an immediate need for action to ensure the safety of all individuals in licensed care facilities and community settings. The ROSE form also acknowledges the contact of Local Law Enforcement and the need for immediate safety planning for all individuals to mitigate imminent risk of serious threat or harm. ROSE forms are submitted for, but not limited to, physical assaults, sexual assaults, missing persons, neglect, injury, death resulting in hospitalizations, suicides, media or potential media contact, or death due abuse or neglect. Submission of the ROSE form provides a wrap around approach to supporting the victim and community.

Adult Foster home providers are mandatory reporters under Oregon Revised Statutes. There is a criminal penalty for failure to report abuse. Assisted Living and Residential Care providers are subject to civil penalties. Licensing rules require facilities to immediately report abuse. Failure to report immediately results in a civil penalty for non-compliance with licensing rules.

The time frames for responding to reports of abuse in in-home settings and licensed facilities other than Nursing Facilities are defined in OAR 411-020-0070 as follows:

(a) COMMUNITY CASES (Non-facility, elder abuse, and APS).

(A) IMMEDIATELY FOR EMERGENCY SITUATIONS: Immediately contact 911 when the evidence presented suggests an emergency situation exists, e.g., that a human life is in jeopardy; the individual is in the process of being harmed due to criminal activity; a medical emergency; a fire; or there is a clear and present danger of harm to self or others;

(B) BY THE END OF THE SAME WORKING DAY:
Initiate an investigation by the end of the same working day when the alleged victim has been identified as being in imminent danger;

(C) BY THE END OF THE NEXT WORKING DAY:
Initiate an investigation by the end of the next working day when the individual is identified as being in a hazardous

situation that may lead to increased harm or risk; or

(D) WITHIN FIVE WORKING DAYS:
Initiate an investigation within five working days when screening determines the situation is problematic, one that is chronic or ongoing, or is a situation where an immediate response is unlikely to change the alleged victim's risk level.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Case managers provide education on the rights and responsibilities of individuals at the time a financial or service case is opened. Information is provided to individuals, family members and/or legal representatives on the process for contacting the case manager or local office Adult Protective Service (APS) Unit to report complaints of abuse or self-neglect. Local ODHS and AAA offices have recorded messages to direct the individual calling in to report abuse or self-neglect to the appropriate number and to call '911' in an emergency.

Written information concerning protections from abuse, neglect, and exploitation to participants or their informal caregivers is provided at least annually or at any reassessment. Additionally, case managers provide information during service planning and regular waivered case management contacts. There are also posters and fliers in all local offices.

ODHS Central APS staff train local ODHS and AAA APS specialists in screening and responding to reports of abuse and self-neglect through a mandatory APS Fundamentals training program, offered virtually and in-person at least four times a year. In-Home Services providers (Homecare Workers) are trained on abuse and neglect in their orientation conducted by Carewell SEIU 503 Training in partnership with the Oregon Home Care Commission. Homecare workers are given a workers' guide that provides guidance on identifying indicators of abuse, being a mandatory reporter, and reporting to the local office. All community-based care providers and staff are required to complete abuse and reporting requirements training prior to beginning service.

ODHS is responsible for and distributes brochures each year on Adult Protective Services and Mandatory Reporting that are widely distributed through the state. Brochures are available in translation and alternative format and are posted on the ODHS website (http://www.oregon.gov/DHS/abuse/Pages/index.aspx). Many local offices have created their own brochures with local resource and contact information.

ODHS works closely with partners on many levels to increase public awareness regarding the identification and reporting of abuse of vulnerable Oregonians. ODHS, the Oregon Department of Justice, the American Association of Retired Persons (AARP), and the Governor's Commission on Senior Services collaborate on presentations, forums and conferences about abuse and exploitation. Between the local offices, the state office, and advocate groups there are 2-5 trainings a month at different sites in the state. Twice a year, during Older American's month and on World Elder Abuse Awareness Day, there are campaigns to educate the public on abuse and exploitation that include presentations, events with the governor or the attorney general, and public service announcements.

ODHS advertises a statewide abuse reporting line, the SAFEline 1-855-503-SAFE(7233) for reporting of abuse of any Oregonians. The SAFEline links callers to the appropriate local office to report their concern. The SOQ also provides the SAFEline number to Oregonians. ODHS also offers translation and alternative formats for reporting.

In licensed facilities, education about protection from abuse is provided though the Residents' Bill of Rights. Sections of the Bill of Rights address the right to be safe and secure and free from abuse and neglect and improper restraint. The Residents' Bill of Rights must be posted in a prominent place. Each resident or resident's designated representative is given a copy of the Bill of Rights. Implementation of a Residents Bill of Rights is mandated under ORS 443.739 for Adult Foster Homes and OAR Chapter 411 Division 054 for Residential Care Facilities and Assisted Living Facilities.

OAR Chapter 411 Division 050 requires ODHS to furnish each adult foster home with a Complaint Notice. This notice must be posted in a conspicuous place and states the procedure for making complaints and has telephone numbers for making complaints to ODHS and the Ombudsman.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

ODHS APD is the appropriate authority for receiving reports, reviewing, and responding to all the critical events or incidents identified in G-1a.

OAR Chapter 411 Division 020, General Adult Protective Services, details the procedures for receiving reports, investigating, and documenting critical events or incidents. In addition to General Adult Protective Services, there are also specific administrative rules for Community Based Care that govern investigations of reports of critical incidents: Foster Care Homes OAR Chapter 411 Division 050; Residential Care Facilities and Assisted Living Facilities OAR Chapter 411 Division 054 and In-Home Services ORS 124.050 to 124.095 mandates the procedures investigations of reportedly abused older adults. In all cases, the response to critical incidents consists of a standard series of APS activities including screening, triage or consultation, on-site assessment, investigation, intervention, documentation and APS Risk Management.

Screening:

Local ODHS and AAA offices must have screeners who receive and review reports about critical events or incidents. All reports that involve the possibility of abuse are screened for protective services. Methods of reviewing involve interviewing and assessing information to determine:

- If the complaint is a critical event or incident that makes the state definitions of abuse (see G-1a);
- If the reported victim is an older adult, age 65 or older, or a person with a physical disability;
- Triage (response timeline). The response time is 911 for emergencies and same working day, next working day, or within five working days for other reports of abuse, depending on the screening risk assessment.

If a report is eligible for Adult Protective Services, then the report is referred on to an APS specialist to provide intervention and conduct an investigation. If a report does not meet criteria for protective services or is not within ODHS jurisdiction, then the screener must find and refer the reporter to appropriate available resources, such as the Ombudsman's Office, other public service agencies, law enforcement, etc. The APS specialist may also provide consultation to the reporter to facilitate report to other responsible entities.

For Serious Incidents, the timelines are different due to the retrospective nature of the incident reporting processes. Serious Incident reports are retrieved from the “closed at intake” APS reports from the prior day. On a daily basis the serious incident (SI) team reviews the APS investigations that were screened out as not meeting APS criteria. Serious Incident Liaison staff triage the reports based on the outlined criteria model. APS reports are processed and evaluated on the day that they are received.

Intervention:

If protective services are needed, then the APS specialist and case manager (if applicable) must provide protective services to reduce or remove the harm or threat of harm. The participant has the right to refuse protective services. If the investigator believes a crime has been committed, local law enforcement is contacted. If the investigator believes that Medicaid fraud has occurred, a referral is made to Oregon Department of Justice, Medicaid Fraud unit. If the reported perpetrator is licensed and the investigator believes there is a licensing concern or substantiated abuse, then a report is made to the appropriate licensing agency.

On-site assessment and investigation:

An APS specialist conducts an evidence-based investigation including on-site assessment of the reported victim, witness interviews, and gathering evidence such as facility, medical, and financial records. The waiver participant has the right to decline participation in the investigation. ODHS contracts with a PhD forensic nurse to evaluate injuries in complex cases. APS specialists will work with multi-disciplinary teams that include law enforcement or other law enforcement contacts to staff complex, difficult, and unclear incidents that have the potential of going to prosecution. The evidence is analyzed in a finding of fact. Based upon preponderance of the evidence a conclusion is determined if wrongdoing is substantiated, not substantiated, or inconclusive. If, in limited situations defined in OAR 411-020-0121, an evidence-based conclusion cannot be reached, the investigation may be closed administratively with no abuse determination.

Documentation:

Every APS screening and investigation is documented in the Centralized Abuse Management (CAM) system, a statewide

database. Intake and investigation reports are generated in CAM that include APS specialist observations, a review of documents and records, summaries of all witness interviews, a summary of evidence, and a conclusion.
The APS specialist has 60 days (licensed facility) or 120 days (in-home) from the date of the report to complete the investigation and generate the investigation report in CAM.

Distribution of investigation report for facility investigations:

For Adult Foster Homes, Residential Care and Assisted Living Facilities, within 60 days of receiving a completed investigation report the Safety, Oversight, and Quality (SOQ) unit must examine the investigation report to determine appropriate corrective actions. Upon completion of the agency's regulatory response determination, written notification must be sent to the complainant (if known), the facility, any person reported to have committed wrongdoing, and the Department's local office. A public copy does not have the name of or any identifying information about the alleged victim, complainants, and all witnesses. Upon finalization of the report and findings, individuals with hearing rights may exercise their right to a hearing or a petition for reconsideration.

Reporting back to reporter and participant for In-home Services investigation. For In-home services, under privacy law, the whole report is confidential. The reporter, when he or she calls, is offered the option of being informed about the outcome of their report. If abuse was substantiated, then the reporter can be informed that appropriate steps were taken. If abuse was not substantiated, the reporter can only be informed that it was not substantiated. The waiver participant may have a copy of the report upon request; for all the other parties identifying information must be redacted.

Per Oregon Administrative Rule, waiver participants in Adult Foster Homes, Residential Care Facilities and Assisted Living Facilities are notified upon determination of findings, which could be any time up to 60 days from the reported incident. Waiver participants living in their own homes may request findings, which could be any time up to 120 days from the reported incident.

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.

ODHS APD Central APS and SOQ units work together to develop operations and policy for APS and manage statewide APS operations and data systems. APD Central APS and SOQ oversee compliance with state and federal laws and ODHS policy and procedures for both the local offices and providers. To maintain quality and assure standardization through the state, APD Central APS and SOQ train the APS specialists, provide information technology, and conduct reviews of investigations, and gather and analyze APS and corrective actions data.

Facility Oversight and corrective actions:

Within 60 days of a report of abuse involving a licensed facility, local ODHS and AAA offices send a completed investigation report to the Safety, Oversight, and Quality (SOQ) unit to be individually reviewed. SOQ reviews for potential rule violations and determines appropriateness of corrective actions or sanctions in accordance with the Administrative Rules. Actions could included, but are not limited to, technical assistance, a warning letter, conditions put on the license, civil penalties, or revocation of the license. In determining appropriate sanctions for Community Based Care facilities, SOQ follows the Compliance Framework Guide.

Once finalized, the completed report cannot be altered. Individuals with contested case or other than contested case rights may file a petition for reconsideration to address potential missing information.

For systemic problems identified (e.g. many serious incidents reported for a facility, investigators encounter unreported or additional incidents in the course of an investigation) in Residential Care and Assisted Living Facilities, a referral is made to the CBC Survey Team who may survey all health and safety issues and compliance with licensing rules. The facility then is required to complete a corrective action plan to remedy any violations.

Local ODHS and AAA foster home licensors are contacted with investigation results and follow-up may include re-inspection or development of an additional corrective action plan.
There are specific administrative rules for Community Based Care that govern oversight of reports about and correction actions for critical incidents: Adult Foster Homes OAR Chapter 411 Division 049, 050, 051, and 052; Residential Care Facilities and Assisted Living Facilities OAR Chapter 411 Division 054.

In-home Services oversight of critical incident reports:

For In-Home Services, the managers in the local ODHS or AAA offices supervise reporting of and response to critical incidents. If there is a complaint or question about the investigation report, then the ODHS Central APS Unit reviews the complaint about the report and works with the local office to resolve the complaint or question in compliance with law and policy.

Additional oversight for both facilities and In-home Services is provided in response to complaints received by ODHS Administration and the Governor's Advocacy Office about ODHS responses to reports of critical incidents that were not resolved to the satisfaction of the person bringing the complaint. The APD Central APS and SOQ conduct a review and, on the basis of this review, ODHS Administration responds to complainant and, if necessary, requires local ODHS or AAA office to correct errors in policy or procedure.

System-wide operation of data systems:

ODHS provides and mandates that the local office use a standardized secure incident reporting forms for documenting reports of abuse and resulting investigations. Intakes and investigations are documented in the Centralized Abuse Management (CAM) system. Serious Incident criteria are in CAM.

When APS staff in local offices receive a report of a critical incident, they enter complete demographic and incident information into the CAM system, which is visible to authorized CAM users around the state for purposes of coordination and oversight. CAM tracks APS timelines (e.g. initial response, investigation completion) and can generate a wide variety of activity and data reports to document APS activities and support quality assurance review of APS work. Reports are used by Operations and Policy Analysts in ODHS Central Office to review quality of response to critical incidents at all levels and guide policy to prevent recurrence.

For facility investigations, the CALMS system is used to process reports and maintain a facility's history. CALMs tracks reports of abuse, investigation outcome, narrative documentation, individual information about alleged victims and

perpetrators, and any sanctions issued. Facility compliance history is available to the public on ODHS' Facility Search webpage.

Examples of how reports are used to provide protections for participants and quality control:

o Corrective actions in the state office can examine the history of corrective actions taken in response to critical incidents for any licensed facility to see if there is pattern that needs attention.
o Quarterly, facility reports are sent to local office and state managers about timeliness of completion of investigation reports.
o The State office can examine reports of open and closed cases for in-home services investigations for compliance with APS requirements in policy, rule, and statute.
o State APS Operations and Policy Analysts refer to the data reports on a regular basis to identify trends, changes in served populations, and means to improve system ability to prevent and respond to abuse, e.g. increase staff education and training, provider training, improve information system technology.

ODHS prepares yearly reports of critical incidents in Oregon involving adults age 65 and older and adults with physical disabilities by, at minimum, living situation, participant characteristics, abuse reporter, relationship of perpetrator to victim, and type of abuse or critical incident. ODHS SOQ staff analyze this data by region, facility type, type of abuse to identify trends and patterns in licensed facilities for follow-up with provider training, corrective action or policy revision.

ODHS staff compile, review and analyze performance data through local office reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to local offices as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. Central office staff follow-up with local offices to ensure appropriate action is taken. A statewide report documenting key performance measures and remediation outcomes is provided to the Medicaid/CHIP Operations Coordination Committee (MOCSC). The MOCSC reviews annual reports on key performance measures to ensure follow-up and compliance.

The MOCSC will review statewide reports that includes statistics, performance measures, and follow-up activities for critical incidents for all populations served under the waiver, including licensing and adult protective services. Where additional information or clarification is needed, the MOCSC will ask ODHS to provide it. The MOCSC will have access all supporting databases, such as that those of the SOQ and ODHS 1915 Waiver QA staff.

A report regarding Adult Protective Services performance is made to the Oregon legislature every two years.

Appendix G: Participant Safeguards

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

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

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

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

Improper use of restraints or the seclusion of residents is brought to the Department's attention by various means.
1. A complaint may be reported directly to the Long-term Care Ombudsman's Office and they would notify ODHS.
2. Mandatory reporters may report abuse or suspected abuse directly to ODHS. Examples include, but are not limited to, physicians, nurses, emergency responders, case managers, nurse consultants, home health nurses).
3. Non-mandatory reporters such as residents (victims or non-victims), occupants of the home, resident family members or other resident representatives, visitors or non-care providers such as repair or maintenance personnel).
4. The Licensor may observe or identify improper use of restraints or seclusion during a routine licensing inspection.

Case managers are responsible for monitoring the service plans of waiver participants residing in all in-home and CBC settings to ensure the services provided adequately meet the individual's care needs. If they observe any use of restrictive interventions, they report it to APS. Community Nurses also monitor for the use of restrictive interventions in Adult Foster Homes. Case managers and Community Nurses are mandatory reporters of abuse. Case managers must have a minimum of direct contact with participants at least four times a year. For individuals who are assessed as high risk, the frequency is at least monthly. Part of the monitoring of the service plan is the assurance of health and safety, which includes observing for the use of restrictive interventions. Community Nurses are authorized for visits, as needed, and will observe for the use of restrictive interventions.

In addition, SOQ surveyors make periodic visits to facilities and report any observed or suspected use of restrictive interventions to local APS specialists. If a local ODHS/AAA licensor or other staff observe that a CBC setting has repeat rules violations, potential for harm or actual harm, the licensor reports the provider to the CBC program team within SOQ. Sanctions will be applied to the CBC setting if there are findings of improper use of restrictive interventions. These sanctions may include a range of penalties, from civil penalties, up to and including, revocation of license.

ODHS is responsible for oversight of the improper use of restraints. ODHS staff compile, review and analyze performance data through local office reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to local offices as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. Central office staff follow-up with local offices and licensors to ensure appropriate action is taken. A statewide report documenting performance measures and remediation outcomes is provided to the Medicaid/CHIP Operations Coordination Committee (MOCSC). The MOCSC reviews annual reports on performance measures to ensure follow-up and compliance.

Data are analyzed using the data gathered during the field office reviews, electronic file reviews and data reports. These data are analyzed using different software packages such as PASW Statistics, Microsoft Access and Microsoft Excel. The data can be sorted and categorized to emphasize trends and patterns that would require corrective action or show areas of training need or policy clarification. The data analysis provides information on performance on a statewide, regional, or local office level.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

Improper use of restraints or the seclusion of residents is brought to the Department's attention by various means.
1. A complaint may be reported directly to the Long-term Care Ombudsman's Office and they would notify ODHS.
2. Mandatory reporters may report abuse or suspected abuse directly to ODHS. Examples include, but are not limited to, physicians, nurses, emergency responders, case managers, nurse consultants, home health nurses).
3. Non-mandatory reporters such as residents (victims or non-victims), occupants of the home, resident family members or other resident representatives, visitors or non-care providers such as repair or maintenance personnel).
4. The Licensor may observe or identify improper use of restraints or seclusion during a routine licensing inspection.

* Case managers are responsible for monitoring the service plans of waiver participants residing in all in-home and CBC settings to ensure the services provided adequately meet the individual's care needs. If they observe any use of restrictive interventions, they report it to APS. Community Nurses also monitor for the use of restrictive interventions in Adult Foster Homes. Case managers and Community Nurses are mandatory reports of abuse. Case managers must have a minimum of direct contact with participants at least four times a year. For individuals who are assessed as high risk, the frequency is at least monthly. Part of the monitoring of the service plan is the assurance of health and safety, which includes observing for the use of restrictive interventions. Community Nurses are authorized for visits, as needed, and will observe for the use of restrictive interventions.

In addition, SOQ surveyors make periodic visits to facilities and report any observed or suspected use of restrictive interventions to local APS specialists. If a local ODHS/AAA licensor or other staff observe that a CBC setting has repeat rules violations, potential for harm or actual harm, the licensor reports the provider to APS or SOQ. Sanctions will be applied to the CBC setting if there are findings of improper use of restrictive interventions. These sanctions may include a range of penalties, from civil penalties, up to and including, revocation of license.

ODHS is responsible for oversight of the improper use of restraints. ODHS staff compile, review and analyze performance data through field office reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to local offices as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. Central office staff follow-up with local offices and licensors to ensure appropriate action is taken. A statewide report documenting performance measures and remediation outcomes is provided to the Medicaid/CHIP Operations Coordination Committee (MOCSC). The MOCSC reviews annual reports on performance measures to ensure follow-up and compliance.

Data are analyzed using the data gathered during the field office reviews, electronic file reviews and data reports. These data are analyzed using different software packages such as PASW Statistics, Microsoft Access and Microsoft Excel. The data can be sorted and categorized to emphasize trends and patterns that would require corrective action or show areas of training need or policy clarification. The data analysis provides information on performance on a statewide, regional, or local office level.

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

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other

individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

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

Appendix G: Participant Safeguards

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

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

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

Improper use of restraints or the seclusion of residents is brought to the Department's attention by various means.
1. A complaint may be reported directly to the Long-term Care Ombudsman's Office and they would notify ODHS.
2. Mandatory reporters may report abuse or suspected abuse directly to ODHS. Examples include, but are not limited to, physicians, nurses, emergency responders, case managers, nurse consultants, home health nurses).
3. Non-mandatory reporters such as residents (victims or non-victims), occupants of the home, resident family members or other resident representatives, visitors or non-care providers such as repair or maintenance personnel).
4. The Licensor may observe or identify improper use of restraints or seclusion during a routine licensing inspection.

Case managers are responsible for monitoring the service plans of waiver participants residing in all CBC settings to ensure the services provided adequately meet the individual's care needs. If they observe any use of restrictive interventions, they report it to APS. Community Nurses also monitor for the use of restrictive interventions in Adult Foster Homes. Case managers and Community Nurses are mandatory reports of abuse. Case managers must have a minimum of direct contact with participants at least four times a year. For individuals who are assessed as high risk, the frequency is at least monthly. Part of the monitoring of the service plan is the assurance of health and safety, which includes observing for the use of restrictive interventions. Community Nurses are authorized for visits, as needed, and will observe for the use of restrictive interventions.

In addition, SOQ surveyors make periodic visits to facilities and report any observed or suspected use of restrictive interventions to local APS specialists. If a local ODHS/AAA licensor or other staff observe that a CBC setting has repeat rules violations, potential for harm or actual harm, the licensor reports the provider to APS or SOQ. Sanctions will be applied to the CBC setting if there are findings of improper use of restrictive interventions. These sanctions may include a range of penalties, from civil penalties, up to and including, revocation of license.

ODHS is responsible for oversight of the improper use of restraints. ODHS staff compile, review and analyze performance data through local office reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to local offices as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods. Central office staff follow-up with local offices and licensors to ensure appropriate action is taken. A statewide report documenting performance measures and remediation outcomes is provided to the Medicaid/CHIP Operations Coordination Committee (MOCSC). The MOCSC reviews annual reports on performance measures to ensure follow-up and compliance.

Data are analyzed using the data gathered during the local office reviews, electronic file reviews and data reports. These data are analyzed using different software packages such as PASW Statistics, Microsoft Access and Microsoft Excel. The data can be sorted and categorized to emphasize trends and patterns that would require corrective action or show areas of training need or policy clarification. The data analysis provides information on performance on a statewide, regional, or local office level.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

- **Medication Management and Follow-Up**

  i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Entity with ongoing responsibility for monitoring participant medication regimens:

SOQ is responsible for monitoring the administration of medications in Residential Care Facilities (RCF) and Assisted Living Facilities (ALF). Local ODHS or AAA offices are responsible for onsite licensing and monitoring Adult Foster Homes.

Methods for conducting monitoring:

RCFs and ALFs: SOQ staff interview facility staff administering medications regarding: performance of the task from pour or setup through pass; knowledge of when and which PRN medication to give; procedure to be followed when the resident refuses to take a medication; the system for securing and accounting for controlled substances. The surveyors observe the medication room and spot check for expired medications in the refrigerator and the temperature of the refrigerator and whether it is locked or in a locked room. They check the accuracy of glucometers. They interview residents if there are questionable issues involving a residents' medications. They observe staff pouring medications and passing medications. They observe insulin, inhalers or other routes in addition to oral medications. They then reconcile the pour or pass with the medical record. (Published survey process guidelines are available on request.)

The facility is required to have a safe medication and treatment administration system that has been approved by a pharmacist consultant, registered nurse or physician. Every ninety days a registered pharmacist or registered nurse must review all medications and treatments administered by the facility to residents. The facility must document their follow-up to the recommendations made by the reviewer.

The monitoring should detect if staff is following the correct protocols for medication administration or not for example any discrepancies between physician orders and the MARs, nursing delegation has been completed appropriately, resident specific parameters for PRN psychoactive medications are in place and being followed.

Caregivers administering medications for residents receiving medications are required to know the specific reasons for use of the psychoactive medication, the side effects of the medication(s) and when to contact a health professional regarding the side effects. Medications given p.r.n. that are given to treat a residents behavior must have specific written parameters and used only after non-pharmacological interventions have been tried with ineffective results. Effects of the medication must be documented. All caregivers must have knowledge of non-pharmacological interventions.

Adult Foster Homes:

As part of the annual licensure, the local ODHS or AAA offices foster home licensing staff review all residents medication records and compare them to the physicians orders, to the medications themselves and the medication labels. They also review the documentation, the PRN charting and the charting of over-the-counter (OTC) medication administration in respect to ODHS Adult Foster Home rules. Local ODHS and AAA office adult foster home licensors review safety, storage and dispensing accuracy of medications and monitor for medication errors.

Frequency of monitoring:

RCF and ALF: Onsite licensing reviews are conducted every 24 months. If systemic issues are identified as part of abuse follow-up by APS, then CCMU conducts an early full survey of the facility.

The monitoring detects if staff is following the correct protocols for medication administration or not. For example any discrepancies between physician orders and the MARs, nursing delegation has been completed appropriately, resident specific parameters for PRN psychoactive medications are in place and being followed.

Caregivers administering medications for residents receiving medications are required to know the specific reasons for use of the psychoactive medication, the side effects of the medication(s) and when to contact a health professional regarding the side effects. Medications given PRN that are given to treat a residents behavior must have specific written parameters and used only after non-pharmacological interventions have been tried with

ineffective results. Effects of the medication must be documented. All caregivers must have knowledge of non-pharmacological interventions.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Methods used to ensure participant medications are managed appropriately:

ALFs and RCFs: A 10% sample of medical records is reviewed during the survey process by SOQ. A survey of the facility's residents is prepared by the facility prior to the survey. If a pattern of high use of psychoactive medications or medication errors is found, their 10% sample will be derived from those residents.

Adult Foster Homes: As part of their annual licensure, the local ODHS/AAA offices foster home licensors review all residents medication records and compare to physician's orders, to the medications themselves and their labels. They also review documentation and PRN charting and OTC administration in respect to ODHS Adult Foster Home rules. ODHS/AAA office adult foster home licensors review safety and storage of medications, and accuracy of dispensing, and monitor for medication errors.

Identification of potentially harmful practices:

RCFs and ALFs: Inappropriate storage, administration errors, etc. are noted in the survey by SOQ. Surveyors also observe medication administration (pouring and passing of medication) and interview the passers.

Adult Foster Homes: ODHS/AAA offices adult foster home licensors review safety and storage of medications, accuracy of dispensing, and monitor for medication errors.

Methods for following up on potentially harmful practices: In all facilities any rule violations are reviewed with the facility at the time of the exit interview. Rule violations will be managed according to administrative rules.

Civil penalties:

License Condition- This is an involuntary action that is taken when the facility has shown a consistent pattern of non-compliance and there has been harm to residents or potential for severe harm. A condition may require the hiring of a nurse or other type consultant, restriction of admissions, etc.

Non-renewal, denial, suspension or revocation when ODHS finds there has been substantial failure to comply with rules including, failure to comply with applicable ordinances and rules relating to safety from fire, failing to implement a plan of correction, failure to disclose or provides incorrect information on the licensing application, imminent danger to health or safety of residents, abandonment of facility operation, loss of physical possession of the premise, loss of operational control of the facility or appointment of receiver, trustee, or other fiduciary court order.

Temporary Manager-action may be taken in cases where the licensee's unwillingness or inability to comply with rules, the imminent insolvency of the facility, the revocation or suspension of license or the Divisions determination that the licensee will cease operations without adequate arrangements for relocation of residents.

Adult Foster Homes are reviewed annually during the licensing review. A registered pharmacist or registered nurse must review all medications and treatments administered by the Residential Care Facilities and Assisted Living Facilities to a resident at least every ninety days. The facility must provide documentation related to the recommendations made by the reviewer. Any findings that would result in a licensing violation are reported to the CCMU by the entity responsible for reviewing the medication records every ninety days.

Long-term Care Ombudsman staff are in the building several times per year visiting residents. If they observe questionable practices, then they will contact licensing staff or CCMU. They may also report concerns to protective services. Case managers conduct reviews on clients and are in facilities numerous times per year. They too contact licensing staff as to any concerns they may have. In addition adult protective services workers may also in conducting complaint investigations. If the complaint investigation reveals numerous or severe problems, Central Office is notified and corrective action may be implemented or surveyors may conduct a survey before the 24 month interval.

ODHS staff compile, review and analyze performance data through local office reviews, electronic file reviews and data reports. Corrective action/remediation plans are submitted to local offices as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly

used remediation methods. Central office staff follow-up with local offices to ensure appropriate action is taken. A statewide report documenting performance measures and remediation outcomes is provided to the Medicaid/CHIP Operations Coordination Committee (MOCSC). The MOCSC reviews annual reports on performance measures to ensure follow-up and compliance.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

◉ **Not applicable.** *(do not complete the remaining items)*

○ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*
Do not complete the rest of this section

- **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).

- **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:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

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:
PM27: Number and percent of unexpected or suspicious deaths that are followed up with according to policy N: Number of incidents of unexpected or suspicious deaths that are investigated appropriately (timely according to policies and procedures) D: Total number of individuals where an unexpected or suspicious death occurs

Data Source (Select one):
Mortality reviews
If 'Other' is selected, specify:

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):*

Performance Measure:
PM26: Number and percent of waiver participants and/or guardians who are informed about the ways to identify and report abuse, neglect and exploitation N: Number of waiver participants and/or guardians who are informed about the ways in which to identify and report abuse, neglect and exploitation D: Total number of waiver participants reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%/10%/50% for all ODHS-operated offices.
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify:	

	Biennially	

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%/10%/50% for all AAA offices
☐ **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

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:
PM29: Number and percent of investigations that were conducted appropriately according to Oregon Administrative Rule 411-020 N: Number of abuse investigations that were conducted in accordance with Oregon Administrative Rule 411-020 D: Total number of files reviewed in which investigation was conducted.

Data Source (Select one):
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:
PM28: Number and percent of initial incidents reports that were filed appropriately (timely according to policies and procedures) N: Number of incident reports completed appropriately (timely according to policies and procedures) D: Total number of files reviewed which contained initial incident reports

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:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
PM30: Number and percent of allegations regarding wrongful restraint and involuntary seclusion where investigations are conducted in accordance with OAR 411-020 N:Number of allegations regarding wrongful restraint and involuntary seclusion where appropriate actions and follow-up occurred D:Total number of files reviewed that included allegations of wrongful restraint and involuntary seclusion.

Data Source (Select one):
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**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **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:
PM31: Number and percent of participants with a risk(s)identified on the risk assessment and monitoring instrument where there is evidence of followup. N:Number of participants with risk(s) identified on the risk assessment and monitoring instrument where there is evidence of follow-up. D:Total number of participants reviewed with risk(s)identified on the risk assessment and monitoring instrument.

Data Source (Select one):
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. Designated staff within
ODHS reviews 100% or a representative sample of individual files case managed by ODHS-operated local offices using a 95%/10%/50% method. The method is per ODHS/AAA office and results in a larger sample size than a statewide

95%/5%/50% method. Upon completion of OHA's analysis and review of ODHS' quality assurance data and reports, all relevant information 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 documents 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.
The 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.
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 local 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 OHA and/or ODHS Quality Management Staff to determine that the corrective action was successfully completed by the local 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 (AAA, Oregon Tribes, 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 14 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 once the plan is accepted or within 30 days.
Completion of corrective actions: Within 6 months, unless additional time is needed because of training availability.
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 60 day tribal input period and 30 day public input period, as well as the 90 day approval process.
Follow-up to determine effectiveness of remediation activities will occur during Corrective Action Plan check-ins and 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. 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: Biennially.

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 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, 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. Cases are continuously reviewed. As the data is always available, data is provided over a 3 year period of time and can include data from 2 separate cycles of review. While the planned 2-year cycle still represents 3 years of data, the data itself is based on the specific parameters requested, in terms of dates.
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 local office. System-wide remediation activities will occur every two years, when required, based on statewide discovery and analysis. Both individual and system-wide remediation activities will require a corrective action plan.
Data and reports gathered and created by ODHS staff during quality reviews and QA activities identified in the performance measures are reviewed and analyzed on a continuous, ongoing basis by the OHA liaison to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Review and remediation activities will be tracked in an electronic system accessible to appropriate ODHS and OHA staff for the purpose of maintaining timelines, ensuring compliance, and to issue reports relating to review and remediation activities.
A Quality Assurance overview report is submitted to the Medicaid/CHIP Operations Coordination Steering Committee (MOCSC). The MOCSC is comprised of the administrators, or their designees, with responsibility for the Medicaid/CHIP program from all appropriate divisions of OHA and ODHS.
The MOCSC annually reviews the reports, documents ODHS and OHA remediation efforts, and offers feedback on trends and implementation of systemic quality improvement activities.
Additionally, the MOCSC meets at least quarterly to coordinate and review all mutual policy issues related to the operation and administration of the Medicaid/CHIP program including state plan amendments, waiver requests, rules, procedures, and interpretive guidance. A Medicaid/CHIP Policy and Operations Steering Committee (Steering Committee) for OHA and 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 local operations. This includes ongoing review and approval of ODHS operational oversight and quality assurance activities.
As the OHA liaison and the MOCSC receive reports of findings and remediation efforts, it informs the Medicaid Director and the Steering Committee outlined above, thus informing executive management of OHA and ODHS.
On an annual basis, ODHS will post quality improvement results on its public website and present to the Governor's Commission on Senior Services and Oregon Disabilities Commission, key advisory committees comprised of a wide variety of stakeholders.

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**	☒ **Other**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
Specify:	Specify:
	Biennially

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Staff from ODHS Central Office (CO), APD and AAAs administer all services delivered through the waiver operated by ODHS, APD. Oregon Tribes/NARA provide case management services, but not eligibility determinations/redeterminations.
APD staff use findings from discovery and remediation activities related to the six assurances and other parameters to establish priorities for system improvement and evaluate the effectiveness of those improvements.
APD staff seek input from participants, families, providers, and other interested parties/groups to find ways to deliver waiver services more effectively and efficiently and move the participant toward outcomes stated in approved plans of care.
APD staff collect QI information from the performance measures related to the six assurances and other topic areas. They work with participants, families, providers, and others to address both concerns raised and improvement opportunities identified. ODHS, Program Integrity staff compile reviews and analyze performance data through a variety of file reviews and data reports. Corrective action/remediation plans are required as areas of improvement are identified. Additional training, technical assistance and policy updates or clarification are the most commonly used remediation methods.
ODHS, APD staff follow-up to ensure appropriate action is taken. A statewide report documenting key performance measures and remediation outcomes is provided to the OHA/ODHS Liaison and the Medicaid/CHIP Operations Coordination Committee (MOCSC). The OHA/ODHS Liaison and the MOCSC review annual reports on key performance measures to ensure follow up and compliance.
Additionally, designated staff within OHA review a representative sample of individual files case managed by ODHS-operated offices using a 95%/10%/50% method. The method is per ODHS/AAA office and results in a larger sample size than a statewide 95%/5%/50% method. For example, if the a statewide number of 27,939 is input into Raosoft using the 95%/5%/50% method, it results in 379 cases to review. When done by ODHS/AAA office using the 95%/10%/50% method, it results in 1,387 cases to review.
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.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Quality Improvement System will ensure that all discovery and remediation activities have a process in place to ensure system improvement. The Oregon Health Authority and 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 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, 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, APD Central Office staff follow-up to ensure appropriate action is taken.
Additionally, OHA exercises oversight of Medicaid/CHIP programs by employing designated staff to partner with ODHS (OHA/ODHS liaison), participating in the 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 local operations. This includes a review of a percentage of files already reviewed by ODHS staff and other program oversight activities. The OHA liaison or designee reviews the processes employed and outcomes reported, by ODHS in order to ensure prompt and accurate level of care determination, participant access to qualified providers, person-centered service planning/delivery, enforcement of safeguards that ensure participant health and safety, and maintenance of financial accountability for all home and community-based waiver service levels.

Appendix 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 Aging and People with Disabilities Waiver the State does not require independent financial statement audits of Waiver Case Management because it is provided by employees of ODHS, the AAAs and Oregon Tribes/NARA.

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.

OHA, Office of Program Integrity:
Audit staff from OHA's Office of Program Integrity, Provider Audits Unit (PAU), review payment records of Medicaid providers continually and on an ongoing based utilizing a prioritized risk analysis and either a random sample method or 100% claim review. Staff set audit priorities each year based upon assessed risk analysis. The random sample is done using a stratified random sample method based on the Calvin Paper or other statistically valid methodology. The estimate of overpayment is made utilizing a simple extrapolation with a standard error of the estimated overpayment and the confidence interval estimate of the total overpayment calculated from the data obtained from the sampled line items. The estimate of total overpayment is obtained by calculating the overpayment for each stratum and summing these overall strata.

A government body, an organization or an individual can trigger an audit.
These auditors may conduct desk audits or on-site local audits as determined by the Auditor and PAU management. Auditors may consider other audits of the provider as described in OAR. Provider and Contractor Audits, Appeals and Post-Payment Recoveries are described in OAR 407-120-1505.

The Office of Payment Accuracy and Recovery, Fraud Investigation Unit (FIU), an ODHS/OHA Shared Service, and OPI,PAU receive reports of fraud in Medicaid programs and investigates allegations. FIU investigates allegations of consumer fraud. PAU investigates fraud allegations against providers such as billing for services not rendered, intentionally billing in duplicate, billing for higher level of services than was delivered, billing for services provided by unlicensed or otherwise ineligible practitioners, and kickback schemes.

PAU sends fraud referrals to the Medicaid Fraud Control Unit (MFCU) where there is a credible allegation of fraud or an unusually high error rate found in the audit. The 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.

Case reviews are conducted by the ODHS QA Team and the OHA Review team. These reviews include desk reviews, electronic file reviews and face-to-face contact with waiver participants to determine that services are being provided as agreed. Case management notes detail the services provided to participants. Documents such as the service plan and the CA/PS assessment are readily available in the electronic file. QA teams review the service plan and assessment to

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

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

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:
PM33: Number and percent of waiver billable claims paid as specified in the approved waiver N: Number of claims appropriately coded and paid for in accordance with the reimbursement methodology. D: Total number of claims coded and paid for files reviewed

Data Source *(Select one):*
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:
PM32: Number and percent of claims approved with appropriate plan of care specified in the approved waiver. N: Number of claims approved in accordance with the appropriate plan of care D: Total number of claims approved for files reviewed

Data Source *(Select one):*
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***

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
PM34: Number and percent of waiver claims approved using appropriate rate methodology specified in the approved waiver. N: Number of approved claims paid using the appropriate rate methodology. D: Total number of claims approved for files reviewed

Data Source *(Select one):*
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. Designated staff within
ODHS reviews 100% of Financial Accountability performance measures. Upon completion of OHA's analysis and review of ODHS' quality assurance data and reports, all relevant information 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 documents 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.
The 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.
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 local 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 OHA and/or ODHS Quality Management Staff to determine that the corrective action was successfully completed by the local 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 (AAA, Oregon Tribes, 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 14 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 once the plan is accepted or within 30 days.
Completion of corrective actions: Within 6 months, unless additional time is needed because of training availability.
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 60 day tribal input period and 30 day public input period, as well as the 90 day approval process.
Follow-up to determine effectiveness of remediation activities will occur during Corrective Action Plan check-ins and 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. 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:* *Biennially.*

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

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

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

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

The monthly case management rate is published on the Aging and People with Disabilities rate schedule. Participants, providers and the general public may access the rate schedule online at https://www.oregon.gov/DHS/SENIORS-DISABILITIES/PROVIDERS-PARTNERS/Pages/index.aspx.

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

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

Transition services rates for moving and move-in costs are the actual, most cost-effective price for the product or service offered through a competitive bidding process using appropriate vendors. The state based the maximum cost for moving on historical costs associated with transition services funded through the 1915(k) optional benefit.

The rate methodology for Housing Supports Services follows the same methodology as that for waivered case management and is based on the costs associated with regional housing support specialists.

Opportunities for public comment and input are provided in accordance with 42 CFR 447.205. The public comment and input process is described in Main-6 of this application.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

a)ODHS' payment systems accesses the MMIS recipient files for Medicaid eligibility, client service eligibility, case management encounters, and provider subsystems to verify client and provider eligibility prior to releasing payments for services for individuals receiving waiver services. If an individual is not eligible for waiver services on the date the service is received, no payment is authorized.

b) The following describes the process and method of payment utilized by ODHS to pay for case management services through a non-MMIS payment system. This description includes the billing process and records retention. Medicaid is the payor of last resort for all services described below.

c) To document expenditures, enrollments and payments, ODHS central office will access monthly reports of the service provided, by provider that are generated from the Oregon ACCESS Case Management System.

d) AAA agencies and Oregon Tribes/NARA are paid for case management services under a contract with ODHS. Case management services provided directly by ODHS staff are factored into the salary paid through the state payroll system.

e) An adjustment will be made in the payroll system for the total of all case management services provided by ODHS staff that will automatically report to the CMS-64.

f) The monthly total will be submitted for payment through our accounts payable system utilizing payment codes that automatically report to the CMS-64.

Transition services - moving and move-in- providers will bill ODHS directly through the use of invoices. Invoices will be paid directly through ODHS payment systems.

The process and method of payment used by ODHS to pay for Housing Support Services is the same as case management services.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

◉ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

a) Client eligibility information is contained in Oregon ACCESS and in MMIS. Waiver Case Management claims are entered into the Oregon ACCESS system. Qualifying encounters are pulled out of Oregon ACCESS and matched with eligible individuals when passed through the payment system.
b) The service plan provides authorization for all state plan and waiver services, including the amount and duration. For all waiver services, the case manager authorizes the specific services to be provided in the service plan. The service plan is confirmed through signatures by the individual (or representative) and the Case Manager. ODHS and OHA staff review authorized services and provision of services during Quality Improvement Reviews. If a service has been claimed without authorization, the claim will be backed out of both the annual 372 expenditure report and the quarterly CMS-64 report.

C) Validation of service provision is accomplished through Quality Assurance reviews. During the course of reviews, ODHS staff review a statistically valid sample of cases to review the authorized service plan with the receipt of authorized services. This is accomplished through direct contact with the individuals who receive services and reviewing case notes/narrative for case management contacts.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ◉ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments to waiver case management providers are made through either the State of Oregon payroll system or through the designated Area Agency on Aging or Oregon Tribe/NARA approved payroll system. Case managers are employees of either State or local government.
Payroll audit processes follow the audit standards for State or local government payroll systems. Payroll reports and RDMS reports are utilized to determine the proportion of payroll attributable to waiver case management. Oregon currently reports these activities as administrative activities on the CMS-64. The same process will be used to claim these activities as waiver expenditures on the CMS-64.
Payments for transition services- moving and move in costs- are made directly through ODHS payment systems. Providers submit an invoice for services rendered. The invoice is prior authorized to ensure the participant is eligible on the date of service and the service is included in the service plan. ODHS payment systems maintain an electronic record of all paid claims that is subject to audit on request. All clean claims are submitted for the appropriate FFP as waiver expenditures on the CMS-64.
Payments to Housing Support Services providers is the same as payments to waiver case management providers.

○ ***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.

☐ ***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:

ODHS local office and, Area Agencies on Aging provide case management services. ODHS offices are State government providers and AAA offices are local government providers, either through counties or through regional Councils of Government.

Appendix I: Financial Accountability

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

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, inter-agency agreements, grants or other similar arrangements with qualified individuals, entities or units of government to furnish Medicaid/CHIP administrative or programmatic services for which 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 States 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 States 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 comprehensive audit coverage. The committee approves an annual audit plan of risk-based and required cyclical audits, then meets every two months, updating the plan as needed based on special requests, investigations, legislative inquiry, or other administrative direction. Auditors have complete access to all necessary activities, records, property and employees. The auditors have no direct authority over activities being reviewed. They abide by the Institute of Internal Auditors Code of Ethics and practices conform to the Standards for the Professional Practice of Internal Auditing, as promulgated by the Institute of Internal Auditors, the American Institute of CPAs (AICPA), the Federal General Accounting Office (GAO) Yellow Book, Institute of Internal Auditors (IIA), and Information Systems Audit and Control Association (ISACA). 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 States 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 states 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 auditors 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:

The Oregon State Legislature will appropriate general funds directly to the Oregon Department of Human Services for funding the waiver. The Oregon Health Authority will request the Federal Match through the CMS 64 process.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or*

sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

◉ ***Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

***c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

***a. Services Furnished in Residential Settings.** Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the***

individual.

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

CBC in 24 hour Residential Facilities: ODHS annually determines the amounts providers must collect from participants for room and board. These amounts are publicized through ODHS policy transmittal processes and input into the CBC provider payment system (512) as an amount that the participant is responsible for paying. The service rate is the only amount the provider can receive from ODHS.

Services to individuals living in their own home: Providers invoice only for hours of service and authorized rates do not include room and board by rule.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	4479.66	43844.49	48324.15	161644.38	4626.81	166271.19	117947.04
2	4571.44	46032.33	50603.77	169710.43	4857.69	174568.12	123964.35
3	4666.56	48329.34	52995.90	178178.98	5100.09	183279.07	130283.17
4	4763.22	50740.98	55504.20	187070.11	5354.58	192424.69	136920.49
5	4861.65	53272.95	58134.60	196404.91	5621.77	202026.68	143892.08

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	50227	50227
Year 2	53743	53743
Year 3	57504	57504
Year 4	61530	61530
Year 5	65837	65837

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.*

The average length of stay was pulled from the most recent 372 report and used for each waiver year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The estimates for Waiver Case Management for Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:
Cost allocation for Waiver case management projected from January 1, 2027 through December 31, 2031.

Cost allocation methodology:

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

The average units per user is each individual receiving a monthly service.

The cost per unit is expected to increase by 2% throughout the waiver period. There is no projected increase in the cost per unit for Transition Services throughout the waiver period. The cost per unit for Housing Support Services will increase by 5% per year starting in year 3.

Service costs estimates were developed using substantially similar services offered in the 1915(k) for individuals transitioning from institutions to HCBS or for individuals receiving 1915(k) services. Nursing costs are based on the costs for Long-Term Care Community Nurses authorized under 1915(k) of the State plan. These rates are published at: https://www.oregon.gov/odhs/transmittals/APDTransmittals/pt25026.pdf.

For Housing Support Services, the estimated growth rates are based on current caseload, discussions with Case Managers, and standard caseload growth.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The estimates of Factor D' for each waiver year are included in Item J-1. The basis for these estimates is as follows:
Actual acute care costs for unduplicated waiver participants from the 2023 APD 372 waiver report plus 2023 1915(k) expenditures projected forward. That total is projected forward by 4.99% for the final three years of the waiver cycle and the first year of the new waiver cycle to establish the Waiver Year 1 (2027) Factor D' estimate. Factor D' estimates are inflated by 4.99% for the entire waiver cycle based on the DRI Inflationary Index used to rebase and project the Nursing Facility daily rate.

The expenditures are post Part D Medicare implementation and reflect the removal of prescribed drugs.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:
Projected cost per day of Nursing Facility services effective January 1, 2027 multiplied by the projected annual length of stay in the waiver. Nursing facility daily rates are determined annually as described in OAR 411-070-0442. Inflation used- 4.99% based on the DRI Inflationary Index used to rebase and project the Nursing Facility daily rate.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The estimates of Factor G' for each waiver year are included in Item J-1. The basis for these estimates is as follows:
The Waiver Year 2 (2023) Factor G' amount is projected forward by 4.99% for the final three years of the waiver cycle and the first year of the new waiver cycle to establish the Waiver Year 1 (2027) Factor G' estimate. Factor G' estimates are inflated by 4.99% for the entire waiver cycle based on the DRI Inflationary Index used to rebase and project the Nursing Facility daily rate.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Waiver Case Management	
Housing Support Services	
Transition Services	

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*
Waiver Case Management Total:							***221428743.12***
Waiver Case Management	☐	Contact	50227	12.00	367.38	***221428743.12***	
Housing Support Services Total:							***1770900.00***
Housing Support	☐	Contact	1000	30.00	59.03	***1770900.00***	

GRAND TOTAL: ***224999643.12***
Total: Services included in capitation:
Total: Services not included in capitation: *224999643.12*
Total Estimated Unduplicated Participants: ***50227***
Factor D (Divide total by number of participants): ***4479.66***
Services included in capitation:
Services not included in capitation: *4479.66*
Average Length of Stay on the Waiver: 284

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services							
Transition Services Total:							**1800000.00**
Transition Services	☐	Transition Service	1000	1.00	1800.00	**1800000.00**	

GRAND TOTAL: 224999643.12
Total: Services included in capitation:
Total: Services not included in capitation: 224999643.12
Total Estimated Unduplicated Participants: 50227
Factor D (Divide total by number of participants): 4479.66
Services included in capitation:
Services not included in capitation: 4479.66
Average Length of Stay on the Waiver: 284

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
Waiver Case Management Total:							**241669372.68**
Waiver Case Management	☐	Contact	53743	12.00	374.73	**241669372.68**	
Housing Support Services Total:							**2213625.00**
Housing Support Services	☐	Contact	1250	30.00	59.03	**2213625.00**	
Transition Services Total:							**1800000.00**
Transition Services	☐	Transition Service	1000	1.00	1800.00	**1800000.00**	

GRAND TOTAL: 245682997.68
Total: Services included in capitation:
Total: Services not included in capitation: 245682997.68
Total Estimated Unduplicated Participants: 53743
Factor D (Divide total by number of participants): 4571.44
Services included in capitation:
Services not included in capitation: 4571.44
Average Length of Stay on the Waiver: 284

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
Waiver Case Management Total:							**263757047.04**
Waiver Case Management	☐	Contact	57504	12.00	382.23	**263757047.04**	
Housing Support Services Total:							**2789100.00**
Housing Support Services	☐	Contact	1500	30.00	61.98	**2789100.00**	
Transition Services Total:							**1800000.00**
Transition Services	☐	Transition Service	1000	1.00	1800.00	**1800000.00**	

GRAND TOTAL: 268346147.04

Total: Services included in capitation:

Total: Services not included in capitation: 268346147.04

Total Estimated Unduplicated Participants: 57504

Factor D (Divide total by number of participants): 4666.56

Services included in capitation:

Services not included in capitation: 4666.56

Average Length of Stay on the Waiver: 284

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
Waiver Case Management Total:							**287864413.20**
Waiver Case Management	☐	Contact	61530	12.00	389.87	**287864413.20**	
Housing Support Services Total:							**3416700.00**
Housing Support Services	☐	Contact	1750	30.00	65.08	**3416700.00**	
Transition Services Total:							**1800000.00**
Transition Services	☐	Transition Service	1000	1.00	1800.00	**1800000.00**	

GRAND TOTAL: **293081113.20**

Total: Services included in capitation:

Total: Services not included in capitation: 293081113.20

Total Estimated Unduplicated Participants: **61530**

Factor D (Divide total by number of participants): **4763.22**

Services included in capitation:

Services not included in capitation: 4763.22

Average Length of Stay on the Waiver: 284

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
Waiver Case Management Total:							**314176797.48**
Waiver Case Management	☐	Contact	65837	12.00	397.67	**314176797.48**	
Housing Support Services Total:							**4099800.00**
Housing	☐					**4099800.00**	

GRAND TOTAL: **320076597.48**

Total: Services included in capitation:

Total: Services not included in capitation: 320076597.48

Total Estimated Unduplicated Participants: **65837**

Factor D (Divide total by number of participants): **4861.65**

Services included in capitation:

Services not included in capitation: 4861.65

Average Length of Stay on the Waiver: 284

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Services		Contact	2000	30.00	68.33		
Transition Services Total:							**1800000.00**
Transition Services	☐	Transition Service	1000	1.00	1800.00	**1800000.00**	

GRAND TOTAL: **320076597.48**

Total: Services included in capitation:

Total: Services not included in capitation: 320076597.48

Total Estimated Unduplicated Participants: **65837**

Factor D (Divide total by number of participants): **4861.65**

Services included in capitation:

Services not included in capitation: 4861.65

Average Length of Stay on the Waiver: 284