Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.4

Submitted by:

State of Oregon, Department of Human Services

Submission Date:	**Amendment Request for Waiver 0117.90.R3: Sent October 8, 2007**

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:

The Oregon Department of Human Services (DHS) requests amendment of waiver #0117.90.R3, to:

- **Increase the annual expenditure entry limit minimum per individual plan for community-based, in-home comprehensive services settings for persons with mental retardation and developmental disabilities, who would otherwise require care in an intermediate care facility for the mentally retarded or related conditions (ICF/MR);**
- **Amend the payment processing system to include the Express Payment Reporting System (eXPRS); and**
- **Amend the effective start date for waiver eligibility to the latter of the following:**
  - **The date of the individual's signature on the Title XIX Waiver Form; or**
  - **The date of enrollment to a DD Home and Community-Based Waiver service; and**
- **Clarify and update the State's procedures for an individual's opportunity to request a fair hearing and the grievance and complaints process at the State level.**

DHS administers these services as Oregon's single state Medicaid agency, through its Seniors and People with Disabilities (SPD) Division.

The Oregon Legislature has approved a cost of living adjustment for waivered service providers.

The currently approved waiver, now in year five of a five-year renewal period, is in the 6-95 format. Oregon is submitting sections of the new 3.4 format that apply to the amendment.

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; do not complete Item A-2*):		
	○	The Medical Assistance Unit *(name of unit)*:	
	√	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)	Seniors and People with Disabilities (SPD)
○	The waiver is operated by		
	a separate agency of the State that is not a division/unit of the Medicaid agency. 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.*		

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, 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:

N/A

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

√	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the 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.*
	Community Developmental Disability Programs (CDDP) as described in **4.** below.
○	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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 *(check each that applies)*:

√	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
	A Community Developmental Disabilities Program (CDDP) is an entity that is responsible for planning and delivery of services for persons with mental retardation or other developmental disabilities in a specific geographic area of the state under a contract with the Department or a local mental health authority. Additionally, CDDPs evaluate and reevaluate individuals for the ICF/MR level of care need and offer individuals the choice between ICF/MR and community-based care. CDDPs operate throughout the State of Oregon in various counties and regions.
○	**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*:
☐	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

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 Department of Human Services, Seniors and People with Disabilities (SPD)

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:

Annual HCBS Waiver Review- of services for approximately 5% of individuals in waiver services conducted by SPD Central Office and CDDP Quality Assurance staff---across all waivers, counties, and brokerages. Data submitted to SPD for central database and reporting.

Employment Outcomes System (EOS)----individual wages, hours worked, integration collected every six months;

Services Coordinator service monitoring- on-site visits to 24-hour residential facilities, Foster Homes monthly or quarterly;

Improvement Projects- QA/QI grant assessing satisfaction in self-directed services; SPD survey every 2 years;

Licensing or Certification Reviews—from 1 to 3 years, depending on type of program;

Office of Investigation and Training (OIT) review of protective services investigations;

Office of Investigative Training (OIT) reports –statewide data by county, type, outcome, victim, perpetrator, provider, etc.;
Serious Event Review Team (SERT) review of provider sanctions---every 2 months;

Improvement Projects- QA/QI grant assessing satisfaction in self-directed services; SPD survey every 2 years; CDDP review of comprehensive in-home service provider qualifications;
Contested Case Review- As requested;

Local QA program- (CDDP) report required by contract, including distribution of resources and status of QA program;
DHS Audit Unit, Secretary of State- other internal or external periodic audit activities; and

Direct Care Staffing- monthly online survey of wages, Full Time Employees, turnover.

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.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	√	☐	☐	√
Assist individuals in waiver enrollment	√	☐	☐	√
Manage waiver enrollment against approved limits	√	☐	☐	☐
Monitor waiver expenditures against approved levels	√	☐	☐	√
Conduct level of care evaluation activities	√	☐	☐	√
Review participant service plans to ensure that waiver requirements are met	√	☐	☐	√
Perform prior authorization of waiver services	√	☐	☐	√
Conduct utilization management functions	√	☐	☐	√
Recruit providers	√	☐	☐	√
Execute the Medicaid provider agreement	√	☐	☐	√
Determine waiver payment amounts or rates	√	☐	☐	√
Conduct training and technical assistance concerning waiver requirements	√	☐	☐	√

Appendix B-2: Individual Cost Limit

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)*:

√	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c.* * **For individuals served under this waiver, the cost of waiver-funded home and community-based in-home services received by the individual must exceed $21,119 per plan year.**
○	**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
	√ Other *(specify)*:
	CDDP Services Coordinators assess waiver needs and prepare individual care plans. For individuals over 18 years of age whose plan of care for comprehensive in-home services will **not** exceed $21,119 per year, SPD enrolls them in the Support Services waiver (#0375).
○	**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: $ _____
	The dollar amount *(select one)*:
	○ Is adjusted each year that the waiver is in effect by applying the following 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: _____ %
	○ Other – *Specify:*

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-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 waiver 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 *(insert number):*	
	1	
ii.	**Frequency of services**. The State requires *(select one)*:	
	√	The provision of waiver services at least monthly
	O	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*):

O	Directly by the Medicaid agency
O	By the operating agency specified in Appendix A
O	By an entity under contract with the Medicaid agency. *Specify the entity*:
√	Other (*specify*):
	CDDP, Services Coordinators are responsible for completing annual level of care reevaluations.

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

Local CDDP, Services Coordinators performing the initial evaluation and annual level of care reevaluation must be a Qualified Mental Retardation Professional, as defined in 42CFR 483.430(a); OR meet the qualifications set forth in Oregon Administrative rule:

OAR 411-320-0030(3)(b)(A)(B):
A person employed as a Services Coordinator or as a Support Specialist must have at least:
(i) A bachelor's degree and two years' work experience in human services; or
(ii) Five years of equivalent training and work experience; and
(iii) Knowledge of the public service system for developmental disability services in Oregon.
(B) Alternative plan to meet qualifications. Persons who do not meet the minimum qualifications set

forth in 411-320-0030(3)(b)(A) may perform those functions only with prior approval of a variance by the Department. Prior to employment of an individual not meeting minimum qualifications a Services Coordinator or a Support Specialist the CDDP must submit a written variance request to the Department. The request will include:
(i) An acceptable rationale for the need to employ an individual who does not meet the qualifications; and
(ii) A proposed alternative plan for education and training to correct the deficiencies.
(iii) The proposal must specify activities, timelines and responsibility for costs incurred in completing the plan.
(iv) A person who fails to complete a plan for education and training to correct deficiencies may not fulfill the requirements for the qualifications.

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

SPD, with the assistance of local CDDPs, uses the Title XIX Waiver form to determine an individual's ICF/MR level of care eligibility for waivered services.

Services Coordinators at local CDDPs complete the Title XIX Waiver Form when an individual is entering a waivered service for the first time, and review it annually thereafter. The Services Coordinator completes the form using personal observations of the individual, interviews with the individual and others with personal knowledge of the individual, and documentation of the individual's functioning from information in the individual's file, such as standardized tests administered by qualified professionals as described in OAR 309-042-0050.
Examples include:

- Vineland;
- Scales of Independent Behavior – Revised (SIB-R);
- Adaptive Behavior Assessment Scale (ABAS); and
- Adaptive Behavior Scale (ABS);
- The SC's personal observations of the individual; and
- Information from the individual's primary caregiver

SPD employs a Diagnosis and Evaluation Coordinator (D & E Coordinator), to whom the SC sends the initial Title XIX Waiver form for review and LOC eligibility determination. The D & E Coordinator determines from the information provided on the Title XIX Waiver form whether the individual meets the ICF/MR level of care eligibility.

The D & E Coordinator reviews the Title XIX Waiver form to ensure:

- That the individual has a qualifying diagnosis of a Developmental Disability; and
- A need for supports in one or more of the following areas:
  - Self Direction;
  - Home Living;
  - Community Use;
  - Social;
  - Self Care;
  - Communication;
  - Mobility; and
  - Health & Safety.

A need for supports may include cueing, reminders, redirection, reassurance, set-up, stand-by or hands-on.

In the event the completed Title XIX Waiver Form does not reflect that an individual has a need for supports in any of the areas listed above, the D & E Coordinator will contact the Services Coordinator at the local CDDP for more detailed information regarding the individual's functioning and need for supports. If the individual has support needs that should be reflected on the Title XIX Waiver Form, the D & E Coordinator will document this information and make a determination of ICF/MR level of care eligibility.
OAR 411-320-0080 governs the criteria used to determine DD eligibility.

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

√	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
O	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:

The above-mentioned diagnostic evaluations establish the presence of developmental disability (ies), including mental retardation. These may include evaluations by physicians, social workers, psychologists, and speech and hearing specialists. After the developmental disability has been established, the Title XIX Waiver form is completed to establish ICF/MR level of care. All individuals considered for the waiver are evaluated for ICF/MR level of care using the Title XIX Waiver Form. The Title XIX Waiver form is completed for individuals discharged from an ICF/MR and for those considered for admission. The department's Diagnosis & Evaluation (D&E) Coordinator signs all Title XIX Waiver forms and designates approval or disapproval of ICF/MR level of care.

Once Title XIX Waiver Level of Care recommendation has been made by the D&E Coordinator, the effective start date for waiver eligibility will be the latter of the following:

- The date of the individual's signature on the Title XIX Waiver Form, or
- The date of enrollment to a DD Home and Community-Based Waiver service.

The D&E Coordinator must be a Qualified Mental Retardation Specialist with extensive knowledge of DD and DD services, with at least two years experience in program evaluation.

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)*:

O	Every three months
O	Every six months
√	Every twelve months
O	Other schedule (*specify*):

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.
O	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

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)*:

CDDPs are given the latitude to conduct the annual face-to-face Level of Care reevaluation (Title XIX Waiver form) at the same time as the annual ISP meeting or at a regularly scheduled face-to-face visit, such as a monthly monitoring visit, within the mandated 12-month time frame. Service Coordinators are required to conduct an individual's annual level of care reevaluation face-to-face to ensure the health and welfare of the recipient. Completion of the annual level of care (LOC) reevaluation cannot exceed 12-months from the date of the last reevaluation.
SPD Central Office staff and CDDP Quality Assurance staff conduct an annual HCBS Waiver Review of services for approximately 5% of individuals in waiver services. The annual HCBS Waiver Review report details aggregate data statewide, by CDDP and brokerage. By conducting the annual HCBS Waiver Review, the state is ensuring that:

- ❖ The TXIX Waiver Form in place;
- ❖ The annual TXIX Waiver Form is timely and current;
- ❖ The TXIX Waiver Form is reviewed at least annually; and
- ❖ There is documentation present supporting eligibility and need for ICF/MR LOC

The review crosses all waivers, counties and brokerages. Data is submitted to SPD by CDDPs and brokerages for entry into a central database, analysis, and reporting to utilize for prospective quality improvement activities.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

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

Appendix B-7: Freedom of Choice

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

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

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

Oregon assures that individuals who are eligible for services under the waiver will be informed, during the completion of the Title XIX Waiver form (Level of Care (LOC) evaluation) and eligibility process, 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 an ICF/MR, the individual or his or her legal representative will be:

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

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

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

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

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

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

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; and, (f) how participants are notified of the amount of the limit.

☐	**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.*
	a) This lower limit (floor) applies to the total minimum cost of all waiver-funded home and community-based services available to individuals served in their home under this waiver each plan year. The currently approved floor is $21,119 per year unless otherwise authorized in accordance with state administrative rules and policy. b) The new limit reflects the amount below which SPD may enroll individuals in the Support Services Waiver (#0375), unless authorized in accordance with state administrative rule and policy. c) SPD adjusts this limit periodically as legislatively authorized. d) If participant needs cannot be met under this waiver, SPD will transfer the participant to the support services waiver or other appropriate setting. e) Participants will be notified when their total annual plan of care is likely to not meet the waiver limit, and informed of the options for service that the participant has under the support services waiver.
☐	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 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.

SPD is implementing new procedures to inform individuals of the right to request an Administrative Hearing, Administrative Review, and appeal rights on an annual basis. During the annual Individual Support Plan (ISP) meeting, the Service Coordinator responsible for developing the plan will inform the consumer and their guardian or legal representative of the consumer's administrative hearings, administrative review, and appeals rights. The consumer or his or her guardian will sign a document stating that they have been informed of the consumer's rights to a hearing, review, or appeal. This document is a permanent part of the ISP process. The appeals, administrative review, and administrative hearings rights will be discussed with the consumer on an annual basis. Additionally, any time the consumer's benefits are denied, terminated or reduced they will be given notice and advised of their administrative hearings and appeals rights.

Notification of rights:

- At eligibility determination;
- At initial Level of Care (LOC)/waiver determination;
- At the time a Notice of Planned Action is issued; and
- Annual Documentation of:
  - ✓ Right to file a complaint
  - ✓ Grievance Process
  - ✓ Administrative Review process
  - ✓ Administrative Hearing process

OAR 411-320-0060(2)(g) states:
(2) Rights of individuals receiving services. Each agency providing any community developmental disability service must have written policies and procedures to provide for and assure individuals the following rights while receiving services:
(g) Notice and grievances. Prior notice of any involuntary termination or transfer from services and notification of available sources of necessary continued services and exercise of a grievance procedure.

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

Individuals/legal representatives who want or decide to contest the planned action complete and submit an Administrative Hearings Request (SPD form 443) to the Service Coordinator at the local CDDP office. The Service Coordinator at the local office forwards the Administrative Hearings Request to the SPD Central Hearings Unit where it is assigned to a DHS Hearing Representative. The Hearing Representatives are centralized and not part of any local office that determines benefits, services, or eligibility. The Hearing Representative reviews the notice sent to the participant to confirm adequacy and accuracy. If the Notice of Planned Action is insufficient or incorrect, the Hearing Representative contacts the local office to correct the Notice of Planned Action, which may or may not result in restoration of benefits until a corrected notice is provided to the participant.

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

- The individual/legal representative voluntarily withdraws the request for hearing;
- DHS withdraws the planned action;
- The planned action is modified (in which case a new notice of planned action is sent to the individual/legal representative and the individual/legal representative once again has appeal rights); or
- The contested case proceeds to hearing before an Administrative Law Judge.

If the individual/legal representative disagrees with the outcome of the contested case hearing before the Administrative Law Judge, the individual/legal representative may ask for a rehearing or reconsideration of the final order. The Individual/legal representative may also file with the Court of Appeals.

SPD maintains an automated database that tracks each phase of the process and the outcome(s) for each individual/legal representative who requests an administrative hearing or administrative review.

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*:

○	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
√	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

√	**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 *(complete the remaining items).*
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Department of Human Services, SPD, ODDS.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Oregon Administrative Rule governs the grievance/complaint system. An individual and/or his or her representative may file a complaint/grievance for any reason. Issues concerning denial, reduction or termination of Medicaid benefits are managed through the formal Fair Hearings and appeals process. All other complaints, not related to the above-mentioned Fair Hearings issues, are handled at the county level. In the event the individual does not agree with the county's decision concerning his or her complaint, he or she may request a State Administrative Review.

The body of **OAR 411-320-0170 Complaints and Grievance** describes, in detail, the processes and timelines involved in the grievance/complaint process.

SPD, ODDS is introducing a standardized form to be used in CDDPs across the State for the purpose of recording consumer complaints. The form is tentatively titled "Developmental Disabilities Services Complaint Form".

The form contains:

- the consumer's name and contact information;
- consumer guardian or representative information, if applicable;
- the nature of the complaint;
- the outcome or action the consumer would like to see taken regarding the complaint;
- the CDDP's or Brokerage's decision or outcome pertaining to the complaint; and
- whether the consumer or guardian accepts, or does not accept, the decision and requests an Administrative Review at the State level.

The above-mentioned form will be made electronically available to CDDPs through the DHS Forms Server. The DHS Forms Server is web-based.

For complaints that are not satisfactorily resolved at the provider or CDDP level, the CDDPs will send a copy of the completed form via e-mail, first class mail, or fax to designated SPD, ODDS staff. Upon SPD's receipt of the form the information will be entered into a complaints tracking database and reviewed thereafter by the designated SPD, ODDS staff.

With the implementation of the new "Developmental Disabilities Services Complaint Form" and the

complaint-tracking database within ODDS, the State will have the capability to consistently track all complaints that cannot be resolved at the local level and, therefore, rise to the State Administrative Review level. Additionally, the outcome of the State's Administrative Review is entered into the database and all information within the database is utilized to track whether the complaint process is timely, identify the development of any potential trends across the State, and in various other Quality Assurance/Quality Improvement activities.

Appendix I: Financial Accountability

APPENDIX I-2: Rates, Billing and Claims

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).

N/A to this amendment.

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

Provider billings for some waiver services flow directly to the State's eXPRS payment system and are paid through the State Financial Management Application or SFMA once the claim has been validated. As of July 1, 2007, the eXPRS System began processing the payments for Residential Facilities, Supported Living Services, Employment and Alternative Services, State Operated Community Programs (SOCP) and Children's Residential. The first direct provider payment was paid from eXPRS on July 2, 2007.
*Please see the attachment at the end of this waiver amendment application titled, "Attachment to Appendix F Express Payment and Reporting System (eXPRS)".

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

○	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):
☐	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public 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 Non-State Public Agencies**. Specify: (a) the non-State public 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.*)

√	**No**. Public agencies do not certify expenditures for waiver services.

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) The claims system contains edits that ensure recipient eligibility prior to approval for payment for any type of provider claim. The Client Maintenance System contains the individual's Medicaid eligibility information. The Claims system reads the eligibility file to ensure eligibility prior to payment. If an individual is not eligible for services on the date the claim is processed and payment is made using State General Fund dollars.

b) All services are prior authorized for payment based on the approved plan of care. For all waiver services, the services coordinator authorizes the specific services to be provided in the plan of care. Providers receive a copy of the plan of care, specifying the services to be provided prior to the provision of services. The Services Coordinator must review and authorize plans for the expenditure of Department funds. The plan must be signed within 5 working days by the Services Coordinator and be authorized using the following standards:

   A. The plan addresses the needs of the individual as defined in OAR 411-320-0120(3);
   B. The plan identifies type, amount, frequency, duration and provider of services;
   C. The plan is signed by the individual and his or her guardian, (if any), and other team members where applicable,
   D. For individuals residing in foster care or residential care, the provider must have an ISP team approved plan of care that documents the supports provided to the individual. Plans for individuals residing in foster care or residential care licensed by other licensing authorities may be authorized without using the state-mandated formats described in OAR 411-320-0120(5).
   E. Prior authorizations establish permission to expend funds for client services and create a limit on DHS payments. After a service has been delivered, the Provider submits a payment claim via eXPRS. The system checks the claim against the prior authorizations and if the claim complies with all authorizations, payment is made to the provider.

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 §74.53.

APPENDIX I-3: Payment

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) 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.
	The following describes the process and method of payment utilized by SPD to pay for waivered 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. **Residential and Day Habilitation (Adult and Children's Group Homes, Supported Living, Prevocational, Supported Employment):** To document payments to providers of these waivered services, SPD central office and providers will maintain monthly reports by service by provider that are generated from the Client Process Monitoring System (CPMS) and the new Express Payment and Reporting System (eXPRS), description attached at the end of this waiver section. As of July 1, 2007, the eXPRS System began processing the payments for group homes, supported living, and employment services. The first direct provider payment was paid from eXPRS on July 2, 2007. CPMS will continue to perform the payment processing functions for the remaining services under this waiver. Both systems document contract utilization and provides financial information for auditing contract performance. The CPMS enrollment form supplies information and data about an individual and tracks the delivery of service. CPMS produces the following reports from this data: Client Termination and Service Adjustment Recording Form; Client Offset Report (residential habilitation only); Provider Financial Statements; and Fiscal Year Reports. These reports include names of individuals served, their Medicaid ID number, dates of service, and total amount billed for each individual. Reports are sent monthly to providers and CDDP's. SPD maintains this information in a computerized database, and reconciles the information monthly and annually to provider payment information maintained in SPD accounting records.
○	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:

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 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:
☐	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.

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 and (b) the types of providers to which such payments are made. 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.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

○	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
√	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, 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 public providers is the same as the amount paid to private providers of the same service.
○	The amount paid to public 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 public providers differs from the amount paid to private providers of the same service. When a public 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:

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 do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	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.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**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.
√	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

○	**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:
√	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
√	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

General Overview:

The Oregon Department of Human Services' Express Payment & Reporting System (eXPRS) is an Internet based payment and reporting system designed to improve payment procedures and business practices in Developmental Disabilities Services. The Express Payment & Reporting System interfaces with other DHS or local systems, as needed, for efficient operation.

Users of eXPRS include staff of the Department of Human Services (DHS), Local Authorities, and Provider organizations. Your access to information in eXPRS, and your authority to initiate actions through eXPRS, is based on permissions and security levels determined by your employer and the State of Oregon Department of Human Services (DHS).

The Express Payment & Reporting System is built upon a foundation of prior authorizations. The prior authorizations establish permission to expend funds for client services and create a limit on DHS payments. After a service has been delivered, the Provider submits a payment claim via eXPRS. The system checks the claim against the prior authorizations and if the claim complies with all authorizations, payment is made to the provider.

As of July 1, 2007, the eXPRS System began processing the payments for group homes, supported living, and employment services. The first direct provider payment was paid from eXPRS on July 2, 2007.

eXPRS is available to all users 24 hours a day, 7 days a week. Standard online reports, custom report options, and downloads will assist you in tracking the status of payments and analyzing your business activity. This secure, online system is as easy to use as online banking!

Attachment #1: Transition Plan