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 (CDDPs) and Support Services Brokerages, 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:*
	Community Developmental Disability Programs (CDDPs): Local CDDP case managers (Support Specialists), perform these standardized functions: - assess/reassess individuals for the ICF/MR level of care need; - offer individuals the choice between ICF/MR and community-based care, and - authorize plans of care written by Brokerage Personal Agents (with the exception of pilot counties in which the Brokerages authorize the plan of care).
√	**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*:
	Support Services Brokerages (Organized Health Care Delivery Systems) SPD contracts with Support Services Brokerages to oversee the assessment of individual need, write the individual plans of care, and coordinate and monitor services. The Brokerages assist individuals to access providers who deliver the waiver services described in the individual plans of care. The State exercises oversight of all plans of care as part of the periodic reviews outlined on the next page of this document (Appendix A: 3). As described in Appendix D, part g, SPD, on a pilot basis, will allow selected Brokerages to authorize the plans of care written by the Personal Agents in their geographic area. SPD will operate the pilots for sufficient time to determine the viability of this alternative process.
☐	**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 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.

Annual Staley Team Field Review of services for 5% of individuals in support services, including provider files associated with services;

Satisfaction surveys-annual brokerage surveys;

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

Licensing or Certification Reviews—Every two years.

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

OIT reports –statewide data by county, type, outcome, victim, perpetrator, provider, etc

Serious Event Review Team (SERT) review of provider sanctions---every 2 months

Contested case review

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.

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.*
○	**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)*:
○	**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 of waiver-funded home and community-based services the individual receives cannot exceed $21,119 per plan year unless prior authorized in accordance with state administrative rules and policy. The annual costs of waiver services may not exceed the cost of ICF/MR level of care.
	The cost limit specified by the State is *(select one)*:
	√ The following dollar amount: $ — $21,119
	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 as necessary.
	○ 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:

The brokerage personal agent assesses the waiver needs of each individual and prepares an individual plan of care. The county service coordinator authorizes the plan of care and assesses the adequacy within the cost limit. For individuals whose plan of care will exceed $21,119 per year, SPD will enroll them in the Comprehensive Services waiver (#0117.90.R3), unless prior authorized in accordance with state administrative rules and policy.

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:
	The CDDP may authorize emergent services as required to assure maintenance of the individual's health and welfare.
☐	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
	○	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: 2
○	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:

Bachelor's degree and one year of work experience in human services, or who has five years of equivalent training and work experience.

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.

The Title XIX waiver form MHDDSD 0520.

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:

As stated in Appendix A, the CDDP case managers (Support Specialists) perform each initial assessment and subsequent reevaluation of the ICF/MR level of care need.

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*):

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. 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)*:

State and county quality assurance staff review the timeliness of level of care reevaluations by incorporating this component into their periodic reviews at least annually.

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:

County CDDP offices.

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.*
	a) This upper limit applies to the total cost of all waiver-funded home and community-based services available to each individual served under this waiver each plan year. The currently approved level is $21,119 per year unless otherwise authorized in accordance with state administrative rules and policy. b) The new limit reflects the amount above which SPD may enroll individuals in the Comprehensive Services Waiver (#0117.90.R3), 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 comprehensive services waiver or other appropriate setting. e) Same as (d). f) Participants will be notified when their total annual plan of care is likely to exceed the waiver limit, and informed of the options for service that the participant has under the comprehensive services waiver.
☐	**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.*
☐	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Individual Support Plan (ISP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check 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-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
√	Other (*specify the individuals and their qualifications):*
	The Personal Agent, an employee of the Support Services Brokerage described in Appendix A, develops the plan of care. The Brokerage assures that individual Personal Agents have the necessary case management and other relevant experience to assess the need and write effective Individual Support Plans.

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

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
√	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

The following specific conditions are outlined in OAR 411-340-0150 (11) – ("Brokerage Referral to Affiliated Entities"):

(11) Brokerage referral to affiliated entities.

(a) When a Brokerage is part of, or otherwise directly affiliated with, an entity that also provides services an individual may purchase with private or support services funds, Brokerage staff must not refer, recommend or otherwise support the individual to utilize this entity to provide services unless:

(A) The Brokerage conducts a review of provider options that demonstrates that the entity's services will be cost-effective and best-suited to provide those services determined by the individual to be the most effective and desirable for meeting needs and circumstances represented in the ISP; and

(B) The entity is freely selected by the individual and is the clear choice by the individual among all available alternatives.

(b) The Brokerage must develop and implement a policy that addresses individual selection of an entity of which the Brokerage is a part or otherwise directly affiliated to provide services purchased with private or support services funds. This policy must address, at minimum:

(A) Disclosure of the relationship between the Brokerage and the potential service provider;

(B) Provision of information about all other potential service providers to the individual without bias;

(C) A process for arriving at the option for selecting the service provider;

(D) Verification of the fact that the service providers were freely chosen among all alternatives;

(E) Collection and review of data on services, purchased by an individual enrolled in the Brokerage, by an entity of which the Brokerage is a part or otherwise directly affiliated; and

(F) Training of Personal Agents and individuals in issues related to selection of service providers.

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) **<u>Supports and information made available to the participant (and/or family or legal representative, as appropriate)</u>.** The Oregon Administrative Rules require a Person Centered Planning process that includes a comprehensive assessment, The Customer Goal Survey. Further 411-340-0110 requires:

(1) Providing basic information. The Support Services Brokerage must make accurate, up-to-date information about the program available to individuals referred for services. This information must include:

(a) A declaration of program philosophy;
(b) A brief description of the services provided by the program, including typical timelines for activities;
(c) A description of processes involved in using the services, including application and referral, assessment, planning, and evaluation;
(d) A declaration of Support Service Brokerage employee responsibilities as mandatory abuse reporters;
(e) A brief description of individual responsibilities for use of public funds;

(b) **Participant's authority to determine who is included in the process**
Plans must be signed by the individual and, in cases where there is a legal representative, the administrative rule requires that the individual be informed as completely as possible. OAR 411-340-0020 (38) states: "Individual Support Plan (ISP)" means the written details of the supports, activities, costs, and resources required for an individual to achieve personal goals. This ISP is developed by the individual, the individual's personal agent, the individual's legal representative (if any), and other persons who have been invited to participate by the individual or individual's legal representative. The ISP articulates decisions and agreements made through a person-centered process of planning and information-gathering. The ISP is the individual's Plan of Care for Medicaid purposes.

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

a) **Who develops the plan, who participates in the process, and what is the timing of the plan?**
This ISP is developed by the individual, the individual's personal agent, the individual's legal representative (if any), and other persons who have been invited to participate by the individual or individual's legal representative. The Personal Agent (PA) writes the plan in accordance with OAR 411-340-0120 (4) that requires a written plan:

The Personal Agent must write an initial ISP that is signed by the individual (or the individual's legal representative) and, unless circumstances allow exception under OAR 411-340-0120(4)(h), dated within 90 days of entry into Support Service Brokerage services and at least annually thereafter. When an individual's legal representative must sign the plan, the individual's Personal Agent must also work with

the legal representative to inform the individual as completely as possible of the contents of the plan and to obtain, to the degree possible, the individual's agreement to the plan. The plan or attached documents must include:

a) The individual's name;
(b) A description of the supports required, including the reason the support is necessary;
(c) Projected dates of when specific supports are to begin and end;
(d) Projected costs, with sufficient detail to support estimates;
(e) A list of personal, community, and public resources that are available to the individual and how they will be applied to provide the required supports;
(f) The providers, or when the provider is unknown or is likely to change frequently, the type of provider (i.e. independent provider, provider organization, or general provider) of supports to be purchased with support services funds; and
(g) Schedule of plan reviews.

(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?

The Customer Goal Survey includes sections on Home Life and Household needs, Medical/Dental and Health, Social and Leisure, Communication, Employment and education, Financial, Transportation. For each section, the survey seeks the preferences of both the individual and any others involved in planning. Each section then specifically asks about strengths, met and unmet needs, potential resources and risks in that life area.

Further OAR **411-340-0120** requires:

(3) Health and safety issues. The planning process must address basic health and safety needs and supports, including, but not limited to:

(a) Identification of risks, including risk of serious neglect, intimidation, and exploitation
(b) Informed decisions by the individual or the individual's legal representative regarding the nature of supports or other steps taken to ameliorate any identified risks; and
(c) Education and support to recognize and report abuse.

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

Brokerages and Personal Agents are charged with addressing all identified needs regardless of whether the needed support is available under the waiver or can be met using other available resources. The tool used to specifically inform individuals of services available under the waiver is the *Roadmap to Support Services* that is given to all individuals upon referral or entry to Support Services and is also available on the internet at http://www.ocdd.org/support_services.htm

Per OAR 411-340-0120 (1) Each Support Service Brokerage must provide or arrange for the following services as required to meet individual support needs:

(a) Assistance for individuals to determine needs, plan supports in response to needs, and develop individualized budgets based on available resources;
(b) Assistance for individuals to find and arrange the resources to provide

planned supports;
(c) Assistance with development and expansion of community resources required to meet the support needs of individuals served by the Brokerage;
(d) Information, education, and technical assistance for individuals to use to make informed decisions about support needs and to direct support providers;
(e) Fiscal intermediary activities in the receipt and accounting of Support Service funds on behalf of an individual in addition to making payment with the authorization of the individual;
(f) Employer-related supports, assisting individuals to fulfill roles and obligations as employers of support staff when plans call for such arrangements; and
(g) Assistance for individuals to effectively put plans into practice, including help to monitor and improve the quality of supports as well as assess and revise plan goals.

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

The Customer Goal Survey includes sections on Home Life and Household needs, Medical/Dental and Health, Social and Leisure, Communication, Employment and education, Financial, Transportation. For each section, the survey seeks the preferences of both the individual and any others involved in planning. Each section then specifically asks about strengths, met and unmet needs, potential resources and risks in that life area.

Per OAR **411-340-0120**:

(3) Health and safety issues. The planning process must address basic health and safety needs and supports, including, but not limited to:

(a) Identification of risks, including risk of serious neglect, intimidation, and exploitation
(b) Informed decisions by the individual or the individual's legal representative regarding the nature of supports or other steps taken to ameliorate any identified risks; and
(b) Education and support to recognize and report abuse.

When applicable, a Nursing Care Plan or a Plan of Care Crisis Addendum is attached to the individual plan of care,

(e) How are waiver and other services coordinated?

Personal agents coordinate all services by assisting the individual to access community and personal resources prior to accessing waiver services. Plan forms include sections to identify other resources available to meet needs.

Per OAR 411-340-0130 (1):

Approved written plan required. A Support Services Brokerage may use support services funds to assist individuals to purchase supports in accordance with an ISP that:
a) Identifies supports that are necessary for an individual to live in his or her own home or in the family home;
(b) Specifies cost-effective arrangements for obtaining the required supports,

applying public, private, formal, and informal resources available to the eligible individual;
(c) Projects the amount of support services funds, if any, that may be required to purchase the remainder of necessary supports and that are within the Basic Benefit limits, unless authorized for supplement to the Basic Benefit according to OAR 411-340-0130(4)(a) through (e);

(f) <u>How does the plan development process provide for the assignment of responsibilities to implement and monitor the plan?</u>
The Personal agent is assigned the responsibility to implement and monitor the plan. OARs require a projection of service dates, projected costs and plan reviews. Plan monitoring is addressed in OAR 411-340-0120 (7):
Periodic review of plan and resources. The Personal Agent will conduct and document reviews of plans and resources with the individual and the individual's legal representative as follows:
(a) At least quarterly, review and reconcile receipts and records of purchased supports authorized by the ISP;
(b)At least annually and as major activities or purchases are completed:
(A) Evaluate progress toward achieving the purposes of the plan, assessing and revising goals as needed;
(B) Record final Support Services fund costs;
(C) Note effectiveness of purchases based on Personal Agent observation as well as individual satisfaction; and
(D) Determine whether changing needs or availability of other resources has altered the need for continued use of support services funds to purchase supports.

(g) <u>How and when is the plan updated, including when the participant's needs change?</u>
The plan is updated at least annually and is also revised whenever preferences, needs or applicable supports change. Circumstances for revision include, per OAR 411-340-0120 96) (b),
Significant changes in the ISP that include, but are not limited to, changes in the types of support purchased with support services funds and changes in supports that will cause total Plan Year expenses to exceed original estimates by more than 10%, but which do not include changes in the providers chosen to provide direct assistance to the individual. .

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

The Customer Goal Survey includes sections on Home Life and Household needs, Medical/Dental and Health, Social and Leisure, Communication, Employment and education, Financial, Transportation. For each section, the survey seeks the preferences of both the individual and any others involved in planning. Each section then specifically asks about strengths, met and unmet needs, potential resources and risks in that life

area.

Per OAR **411-340-0120**:

(3) Health and safety issues. The planning process must address basic health and safety needs and supports, including, but not limited to:

(a) Identification of risks, including risk of serious neglect, intimidation, and exploitation
(b) Informed decisions by the individual or the individual's legal representative regarding the nature of supports or other steps taken to ameliorate any identified risks; and
(c) Education and support to recognize and report abuse.

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.

Once a waiver service has been determined to be necessary, Personal agents ask if the individual has a potential provider or if the resources known to the Brokerage need to be accessed. Brokerages maintain listings of qualified providers that describe their service areas and other pertinent information. OAR 411-340-0110 (1) (f) (C) states:

Providing basic information. The Support Services Brokerage must make accurate, up-to-date information about the program available to individuals referred for services. This information must include:

An explanation of individual rights, including rights to:

(A) Choose a Brokerage among Department contracted Brokerages in an individual's county of residence;
(B) Choose a Personal Agent among those available in the selected Brokerage;
(C) Select providers among those qualified according to OAR 411-340-0160, 411-340-0170, and 411-340-0180 to provide supports authorized through the ISP;
(D) Direct the services of support providers; and
(E) Raise and resolve concerns about Brokerage services, including specific rights to notification and hearing for Medicaid recipients according to OAR 411-340-0060(3) when services covered under Medicaid are denied, terminated, suspended, or reduced.

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):

As part of an ongoing quality assurance program, DHS Staff conduct field reviews and certification visits on a regular basis.
On a pilot project basis, SPD will allow approved brokerages to authorize plans of care written by their personal agents in specified counties . DHS staff will review a minimum of 5% of these service plans on no less than an annual basis and will provide technical assistance on an ongoing basis. The Brokerage Director or supervisory staff, in pilot

areas, will also be responsible for developing an ongoing internal review process that includes a statistically valid sample of plans for technical compliance with all DHS rules. In non-pilot areas, the CDDP Case managers will continue to authorize all plans of care written by brokerage staff, DHS staff will review a minimum of 5% of these service plans on no less than annual basis and will provide ongoing technical assistance as needed.

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

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
√	Every twelve months or more frequently when necessary
○	Other schedule (*specify*):

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 §74.53. Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
☐	Operating agency
☐	Case manager
√	Other (*specify):*
	Support Services Brokerage

Appendix D-2: Service Plan Implementation and Monitoring

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

After CDDPs or approved pilot Brokerages authorize plans of care, Brokerage staff monitor implementation of the plans. The Oregon administrative rules, at **411-340-0120 (7)** require periodic review of plan and resources. The Personal Agent will conduct and document reviews of plans and resources with the individual and the individual's legal representative as follows:
(a) At least quarterly, review and reconcile receipts and records of purchased supports authorized by the ISP;
(b) At least annually and as major activities or purchases are completed:
(A) Evaluate progress toward achieving the purposes of the plan, assessing and revising goals as needed;
(B) Record final Support Services fund costs;
(C) Note effectiveness of purchases based on Personal Agent observation as well as individual satisfaction; and
(D) Determine whether changing needs or availability of other resources has altered the need for continued use of support services funds to purchase supports.

State staff conduct annual reviews of a random sample of 5% of all Plans of Care and specifically look at assessment of risk and safety factors.

b. Monitoring Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
√	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Brokerages may be stand alone organizations or may be part of a larger organization that also provide direct services, the following Oregon Administrative Rules are in place to provide safeguards:

OAR 411-340-0150 11 (b) The Brokerage must develop and implement a policy that addresses individual selection of an entity of which the Brokerage is a part or otherwise directly affiliated to provide services purchased with private or support services funds. This policy must address, at minimum:
(A) Disclosure of the relationship between the Brokerage and the potential service provider;
(B) Provision of information about all other potential service providers to the individual without bias;
(C) A process for arriving at the option for selecting the service provider;
(D) Verification of the fact that the service providers were freely chosen among all alternatives;
(E) Collection and review of data on services, purchased by an individual enrolled in the Brokerage, by an entity of which the Brokerage is a part or otherwise directly affiliated; and
(F) Training of Personal Agents and individuals in issues related to selection of service providers.

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

√	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
○	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

○	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
√	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

(a) Nature of opportunities for participant direction. SPD provides opportunities for participants to exercise Employer Authority in Support Services. Participants may find their own candidates for employment, screen otherwise qualified candidates for ability to meet participant needs, hire, supervise, direct and discharge employees enrolled as qualified Providers. Participants establish work schedules and train employees in how they prefer to receive their services.

Participants have the opportunity to exercise budget authority over their Individual Support Plan. SPD offers a basic benefit level to all participants as well as enhanced funding based on an assessment (Basic Supplement Criteria Inventory) for extraordinary care needs and particular caregiver circumstances. A comprehensive assessment (Customer Goal Survey) is completed for all participants. Within the participant's benefit level and based upon the necessary supports identified in assessments, the participant chooses what supports are desired. Within SPD rate guidelines, participants choose the rate of pay that providers receive.

(b) Process for accessing participant-directed services. The Support Services Brokerage Personal Agent will discuss various waiver services options with every eligible individual/legal representative who chooses home and community-based services. When

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the preference is to receive waiver services at home, the Case manager will inform the individual/legal representative of the option to receive them from a domestic employee, independent provider or provider organization.

Decision making authority for budgets is afforded to all participants and is built into the initial and ongoing Individual Support Plan development processes for Support Services.

(c) Entities involved in supporting participant direction and supports provided.

1) Information and assistance in support of participant direction:

- Support Services Brokerages maintain lists of providers who have met minimum qualifications as defined by Oregon Administrative Rules (411-340-0160, 411-340-0170) including a criminal history check conducted by DHS. Participants may also select their own providers who are referred to the Support Services Brokerage for qualification.
- Supports to the employer include, but are not limited to: education about employer responsibilities; orientation to basic wage and hour issues; use of common employer-related tools such as job descriptions; and fiscal intermediary services.
- The participant-employer may also request further assistance of the Support Services Brokerage in working with providers.
- Most Support Services Brokerages have developed an orientation for Providers that describes roles and responsibilities of participants, Support Service Brokerages and Providers.
- The Support Services Personal Agent monitors the service plan, identifying risks and unmet needs and discussing options with individuals. At a minimum, reassessments of the functional abilities and unmet needs are completed once a year. Personal Agents are expected to identify and monitor more closely if the situation warrants, for example if the individual's health is particularly fragile, if there are provider issues, mental health concerns or protective service issues. The participant has the right to fire the provider at any time, for any reason.
- Support Services Brokerages assist the participant in creating an individualized budget based upon assessments of disability related needs, monitoring provider services and expenditures, reconciling expenditures against the individual budget and perform fiscal intermediary functions on behalf of the individual.

2) Financial management services:

- Support Services Brokerages issue payment to the qualified provider and handle tax and other employer-related financial requirements on behalf of the participant-employer. The participant-employer signs off on time sheets and invoices verifying the number of hours their employee worked, up to the maximum monthly hours authorized by the Individual Support Plan. Support Services Personal Agents may also verify services provided by direct or telephone contact with the participant
- Support Services Brokerages create job descriptions and service agreements based on the Individual Support Plan.
- Support Services brokerages may contract with an outside Fiscal intermediary (FI) or may perform the FI duties themselves. In either situation, the Brokerage is responsible for assuring financial management services are provided appropriately.

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

○	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
√	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

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

√	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	Waiver is designed to support only individuals who want to direct their services.
√	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

All waiver eligible individuals are informed of the variety of service options available to them including support services when they apply for home and community based services. Individual assistance is provided to the participant from their Support Services Brokerage as requested, including the provision of referrals to qualified providers that the participant can

interview.

Oregon Administrative rules (411-340-0110 (1)) require the provision of basic information by Support Services Brokerages to participants upon entry to Support Services including the right to choose a Support Services Brokerage within their geographic area, select among available Personal Agents, select among qualified providers, direct the services of providers and raise and resolve concerns about Brokerage services, including specific rights to notification and hearing for Medicaid recipients according to OAR 411-340-0060(3) when services covered under Medicaid are denied, terminated, suspended, or reduced.

Participants, upon entry into Support Services, are informed of their individual responsibility for use of public funds and acknowledge this information by signing a document entitled" Responsibility For use of Public Funds". Participants also acknowledge by signature that they may only use qualified providers and the limits of payment by the Support Services Brokerage based upon the individualized budget.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

○	The State does not provide for the direction of waiver services by a representative.	
√	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:	
	√	Waiver services may be directed by a legal representative of the participant.
	√	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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Participant approved friends or family members may supervise the completion of work provided by the provider. A relative or friend who is a paid provider may not sign off on his or her own timesheets or invoices showing the hours worked. All family members, neighbors, friends and other persons involved in the participant's life are assessed as natural supports before any paid supports are included in the Individual Support Plan. Payment can only be made for needs unmet by natural supports

Oregon Administrative Rules (411-340-0140) prohibit services when there is sufficient evidence to believe that the individual or individual's representative has engaged in fraud or misrepresentation, failed to use resources as agreed upon in the ISP, refused to accept or delegate record keeping required to use Support Service Brokerage resources, or otherwise knowingly misused public funds associated with Brokerage services

Based upon Oregon Administrative Rules (411-340-0130 (9)), Support Services Brokerages may sanction any provider who has billed excessive or fraudulent charges or been convicted of fraud or has falsified required documentation. Sanctions imposed include withholding payment to the provider and temporarily or permanently disqualifying a provider from receiving Support Services funds.

Support Services Brokerages refer any cases involving allegations of financial exploitation to Protective Services and/or to the State of Oregon Medicaid Fraud Unit.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3 . *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
All Waiver Services described in pages S-5 through S-7 and Appendix B of currently approved waiver:		
Supported Employment	√	√
Community Living	√	√
Community Inclusion	√	√
Environmental Adaptations	√	√
Non-Medical Transportation	√	√
Specialized Medical Equipment and supplies	√	√
Chore Services	√	√
Personal Emergency Response Systems	√	√
Family Training	√	√
Special diets	√	√
Specialized Supports	√	√
Physical Therapy	√	√
Occupational Therapy	√	√

Speech/Hearing/Language Services	√	√
Emergent Services	√	√
Support Service Brokerage	√	√
Homemaker	√	√
Respite	√	√
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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

√	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*	
	☐	Governmental entities
	√	Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i*.	

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

√	FMS are covered as the waiver service entitled as specified in Appendix C-3.	Support Services Brokerage
○	FMS are provided as an administrative activity. *Provide the following information:*	
	i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:

Support Services Brokerages or subcontracted Fiscal intermediaries perform these services on behalf of the participant when the participant chooses Support Services:

- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.
- Support Services Brokerages facilitate completion of the INS I-9 form and the W-4 form for income tax withholding when a provider enrolls, along with other necessary application paperwork needed for provider enrollment.
- Support Services Brokerages process and pay all vendor and provider invoices.
- Support Services Brokerages maintain all employer and vendor related paperwork on behalf of the individual

ii. **Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:

Support Services brokerages are compensated at a rate of 10.5% of the total administrative budget (Service element 148) based on the model budget developed for brokerages.

iii. **Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*

Supports furnished when the participant is the employer of direct support workers:

√	Assist participant in verifying support worker citizenship status
√	Collect and process timesheets of support workers
√	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
☐	Other *(specify):*

Supports furnished when the participant exercises budget authority:

☐	Maintain a separate account for each participant's participant-directed budget
√	Track and report participant funds, disbursements and the balance–of participant funds
√	Process and pay invoices for goods and services approved in the service plan
√	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
☐	Other services and supports *(specify)*:

Additional functions/activities:

☐	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
√	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
☐	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
☐	Other *(specify):*

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

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

- Annual Field Reviews conducted by SPD staff that review 5% of participant files including all fiscal and financial records. Expenditures are reviewed for being allowed under the waiver and Oregon Administrative rule, prior authorization in the Individual Support Plan and whether expenditures are accurately and appropriately assigned and reported.
- All expenditures are reported monthly to SPD from Support Services Brokerages via the CPMS (Client Process Monitoring System). SPD staff identifies inconsistencies based on waiver and Brokerage enrollment dates and expenditures that appear anomalous and follow up with SPD staff assigned to liaison with Support Services Brokerages to see correction of errors.
- The Department of Human Resources (DHS) Audit & Consulting Services Division conducts periodic reviews of programs administered by DHS, Support Service Brokerages were audited in 2004.
- Support Services Brokerages are required by contract to monitor services provided by Fiscal Intermediaries when these services are subcontracted out. In practice, this is done monthly as billings and tax withholding are reconciled against individual plan budgets,
- Support Services Brokerages are required by contract to comply with applicable audit requirements and responsibilities of the Office of Management and Budget (OMB) Circular A-133.
- Certification reviews every two years by state staff.

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

√	**Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
	Community Developmental Disability Programs (CDDPs) assist participants to choose Waiver services. When enrolling participants into Support services, CDDP case managers inform participants of the services and funding levels available under the waiver. A booklet entitled A Roadmap to Support Services (available here: http://www.oradvocacy.org/pubs/Roadmap.pdf) is given to participants upon referral to explain the program.
☐	**Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled:
☐	**Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

As part of the waivered service and by Oregon Administrative Rule (411-340-0120), Support Services Brokerages must provide or arrange for the following services:

- Assistance for individuals to determine needs, plan supports in response to needs, and develop individualized budgets based on available resources;
- Assistance for individuals to find and arrange the resources to provide planned supports;
- Assistance with development and expansion of community resources required to meet the support needs of individuals served by the Brokerage;
- Information, education, and technical assistance for individuals to use to make informed decisions about support needs and to direct support providers;
- Fiscal intermediary activities in the receipt and accounting of Support Service funds on behalf of an individual in addition to making payment with the authorization of the individual;
- Employer-related supports, assisting individuals to fulfill roles and obligations as employers of support staff when plans call for such arrangements; and
- Assistance for individuals to effectively put plans into practice, including help to monitor and improve the quality of supports as well as assess and revise plan goals.
- Support Service Brokerages must apply the principles of self-determination as defined in OAR 411-340-0020(62) to provision of services required in OAR 411-340-0120(1)(a) through (g).

k. Independent Advocacy *(select one)*.

○	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
√	**No.** Arrangements have not been made for independent advocacy. However, participants are informed of their rights to seek advocacy via The Oregon Advocacy Center, the Governor's Advocacy Office, Legal Aid, The Arc of Oregon and local ARC chapters, etc

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

Participants who voluntarily terminate Support Services are referred to the CDDP who act as gatekeeper to other available services.

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

Participants may exit Support Services and enter Comprehensive Services via the Crisis system when their needs are greater than can be met under Support Services. Transition into comprehensive services is governed by OAR 411-320-0160. Participants entering Crisis

Services via Support Services have a "Support Service Brokerage Plan of Care Crisis Addendum" that serves as a bridge document if the participant exits Support Services and enters Comprehensive services. This addendum covers areas including health and safety, medical, financial and behavioral. Additionally, OAR 309-041-1220 (2) (c) allows for a specific number of newly created Comprehensive placements outside of the Crisis system, these placements are available to participants in the Support Services Waiver.

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

Table E-1-n		
	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		**4,294**
Year 2		**4,849**
Year 3		**5,394**
Year 4 (current 07/08 year)		**5.821**
Year 5		**5,973**

Appendix E-2: Opportunities for Participant-Direction

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

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☐	**Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee.:*
√	**Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

√	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
√	Select staff from worker registry
√	Hire staff (common law employer)
√	Verify staff qualifications
√	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	When such costs exist, as for fingerprinting, service providers pay these.
√	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
√	Determine staff duties consistent with the service specifications in Appendix C-3.
√	Determine staff wages and benefits subject to applicable State limits
√	Schedule staff
√	Orient and instruct staff in duties
√	Supervise staff
√	Evaluate staff performance

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√	Verify time worked by staff and approve time sheets
√	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
√	Other *(specify)*:
	Discharge any provider of service or vendor of supplies

b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply*:

√	Reallocate funds among services included in the budget
√	Determine the amount paid for services within the State's established limits
√	Substitute service providers
√	Schedule the provision of services
√	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
√	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
√	Identify service providers and refer for provider enrollment
√	Authorize payment for waiver goods and services
√	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Support Services offers a basic benefit level to all participants as well as an enhanced benefit level in the form of a supplement to the Basic benefit. To receive the supplement the participant requests an assessment called the Basic Supplement Criteria Inventory (BSCI), administered by the Support Services Brokerage. The BSCI assesses a series of disability related support needs and caregiver circumstances and assigns scores to each section. Based upon the score received, the participant is granted access to one of two levels of enhanced funding.

Within the assigned benefit level, and based upon a person centered Customer Goal Survey that assesses met and unmet needs as well as documenting existing natural supports, participants may choose which allowable goods and services are necessary to

meet their needs. Costs are estimated based upon SPD published allowable rates and other limitations imposed by Oregon Administrative Rule. The tally of waiver goods and services included in the Individual Support Plan becomes the individualized budget for the participant.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Prior to waiver enrollment, CDDPs inform individuals of the budget limits for Support Services. Support Services Brokerages inform individuals of funding levels and criteria for enhanced funding upon entry. Oregon Administrative Rules (411-340-0130 (4) (a)) specify the process for requesting an enhanced benefit level for participants with extraordinary needs as such:

- Individual or legal representative requests in writing an assessment using DHS Form 0203, Basic Supplement Criteria Inventory (BSCI).
- Personal agents assist with this request as necessary.
- Brokerage Director or designee, who have received SPD approved training, administer the BSCI within 30 days of the request.
- The Brokerage Director or designee must score Basic Supplement Criteria according to written and verbal instruction received from the Department.
- The Brokerage Director or designee must send written notice of findings regarding eligibility for a supplement to the Basic Benefit to the individual and the individual's legal representative within 45 calendar days of the written request for a supplement. This notice must include the process for appeal
- Annual ISP reviews for recipients of the supplement must include a review of circumstances and resources to confirm continued need

Within a participant's assigned benefit level, changes to the individualized budget, once established, must be justified by a change in the participant's needs or existing paid and unpaid supports.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
√	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Oregon Administrative Rules (411-340-0120 (7)) require that Support Services Brokerages:

At least quarterly, review and reconcile receipts and records of purchased supports authorized by the ISP.
At least annually and as major activities or purchases are completed

- Evaluate progress toward achieving the purposes of the plan, assessing and revising goals as needed;
- Record final Support Services fund costs
- Note effectiveness of purchases based on Personal Agent observation as well as individual satisfaction
- Determine whether changing needs or availability of other resources has altered the need for continued use of support services funds to purchase supports.