SECTION I: DEFINING SUPPORT SERVICES AND SERVICE UNITS

This section covers:

- ✓ The similarities and differences between comprehensive and support services
- ✓ Services that a support services customer can purchase
- ✓ Services that a provider organization can sell
- ✓ Medicaid requirements that guide service delivery
- ✓ What a service unit is and why it is important

Moving To Individualized Services and Rates

At present, provider organizations serving individuals with developmental disabilities contract for and are paid for an established package of services for a designated number of individuals in agency slots. Self-Directed Support Services expects individuals to utilize a Brokerage and Personal Agent (PA) to help them define the services they need, identify resources available, and negotiate with providers for the purchase and delivery of essential supports. Since most provider organizations will continue providing traditional slot based comprehensive services and the new support services, an understanding of the systems is essential. Table 1 compares similarities and differences in service expectations, contracting and rate setting for organizations under comprehensive and support services.

Selection of Provider Organizations

The Oregon Administrative Rule for Support Services for Adults with Developmental Disabilities (OAR 309-041-1750 through 309-041-1920) and the State Medicaid Waiver define 16 broad support services that individuals can purchase with available support funds. Before actually providing any supports, an organization must:

1. Be a certified or licensed organization and assure that each staff person meets identified qualifications and standards;
2. Clearly define support services for sale;
3. Establish a rate for each service and support;
4. Be chosen by the individual customer; and
5. Be identified by the customer to be competent to meet desired support needs.

Table 1: Comparison of Comprehensive and Support Services

	Comprehensive Services	Support Services
Eligibility and Provider Selection	County establishes eligibility and need for 24 hour paid supports and matches to available services.	County establishes DD eligibility services and customer chooses a provider to meet established goals.
Entry or Exit From Service	Meeting lead by case manager or provider organization staff with documentation requirements. Decisions based on team consensus.	PA assists individual to identify possible service agencies, interview potential providers, select and contract with a provider. Decisions based on customer needs and satisfaction, rates and resources available.
Individual Support Plan (ISP)	ISP Team, including all current service providers, empowered to make decisions with and for an individual.	ISP developed based on person-centered plan usually prior to provider identification. ISP team selected by individual. Minimum team may be individual and PA.
Services Provided	Provider responsible to provide 25 hours per week of any or all of 15 Day Habilitation services needed by the individual.	Individual contracts for desired supports. The content, hours and outcomes are negotiated with the help of the PA.
Contract and Rate Method	County contract with provider. Blended rate.	Individual contract with the provider. Fee for Service rate.
Basis for Rate Identification	Acceptance of a rate based on State developed or negotiated model budget(s).	State establishes range of rates based on customary charges. Provider establishes rate.
Payment	Prospective monthly payment	Pay after services delivered.

Qualification of Provider Organizations and Staff

The Oregon Administrative Rule for Support Services for Adults with Developmental Disabilities (OAR 309-041-1750 through 309-041-1920) establishes standards for provider organizations and for independent providers paid with support service funds. The OAR is available on-line at: http://arcweb.sos.state.or.us/banners/rules.htm

The Support Services For Adults Medicaid Waiver requires that the state **assure the use of qualified providers in the delivery of all identified services from the first day of operation**. A provider organization must demonstrate the ability to meet all qualifications. A current license or certificate for the provision of residential or day services will qualify existing agencies to provide some self-directed services.

✓ If your agency has a current license for 24-Hour Residential or Adult Foster Home Services or certification to provide Employment, Alternatives to Employment or Supported Living Services then your organization is considered initially qualified at the agency level to provide some support services. Certification for other services will require further demonstration of staff competencies.

Table 2: Support Services That Licensed or Certified Provider Organizations are Qualified To Provide

- **Supported Employment**
- **Community Inclusion** (could include sheltered employment or alternative (ATE) type supports)
- **Community Living**
- **Respite Care**
- **Transportation**

✓ If your agency does not have a current license for 24-Hour Residential or Adult Foster Home Services or certification to provide Employment, Alternatives to Employment or Supported Living Services, you should:

- Talk to your local brokerage(s) about requirements and;
- Contact the Seniors and People with Disabilities, Licensing Unit, (503) 947-1082 to request an Application For Support Services Certificate. The criteria for certification are identified in OAR 309-041-1910 (pages 52-61) of the rule. An organization cannot be paid without certification.

From the first day forward qualified staff must deliver all service. This is an important concept that will influence how an organization sets rates, defines services and allocates staff.

- Pre-service or initial staff training is not an allowable cost in the rate setting process.

- Staff already employed in a licensed or certified comprehensive service noted above who will also support new customers will be considered qualified because the organization assures compliance with identified staff qualifications including core competencies and or established annual levels of in-service training.

- Each newly hired staff that work exclusively with support service customers or provide support services identified below must meet the **general independent provider qualifications** identified in Section 309-041-1900 (page 50-52) of the rule. These include:
  - Be at least 18 and not a spouse of the individual supported;
  - Be eligible to work in the US, have a completed criminal history check and not be an excluded Medicaid provider;
  - Demonstrate by a variety of defined methods the background, education, skills and abilities to safely and adequately perform the tasks;
  - Demonstrate an understanding of confidentiality;
  - Hold a current valid professional license or certificate when required; and or
  - Hold a valid driver's license and insurance, if providing transportation.

A Brokerage will require documentation and demonstration of staff qualifications, education, skills, and abilities prior to the initiation of a service contact.

Table 3: Staff Qualifications for Other Support Services

Support Service	Staff Qualifications
Chore Services	General qualifications listed previous page
Homemaker Services	
Special Diets	Licensed Dietician
Family Training	Licensed psychologist, social worker, counselor or medical professional
Occupational or Physical Therapy	Relevant, education, license or certification, and experience
Speech and Language Therapy	
Specialized Supports Behavioral Supports Social Sexual Support Nursing Support	Behavior Consultant with a BA, 3 or more years experience and at least 2 days of OIS training. Social-Sexual Consultant resume with targeted degree and required experience. Current nursing license and 1 year experience with DD.
Environmental Accessibility Adaptations	Licensed building or general contractor with related experience.
Personal Emergency Response Systems	NA
Specialized Medical Equipment and Supplies	

Medicaid Requirements for Individualized Services and Supports

Federal regulations, Oregon's Support Services For Adults Medicaid Waiver and the implementing administrative rule provide the framework for the purchase of services. The following are basic expectations:

1. Each Support Service is Separate and Distinct.

Separate definitions and rates must be developed for each category of support services a provider organization desires to sell. Support services cannot be mixed. For example, daily customer transportation to a specific service cannot be included in the definition, pricing, or billing of another service. This example is especially important for provider organizations that presently mix transportation and day service (DD 54) or residential (DD 50) services for persons in comprehensive services.

2. Each Customer has a Distinct Budget and Contract for Services.

Brokerages will assist each person in defining specific services and goals in an ISP and in allocating resources to match them. Following a process of provider selection, a separate budget and contract for specified services including service units and goals will be developed. This is done one person at a time.

The Support Services for Adults Administrative Rule OAR 309-041-1870(7) (a) (A through E) establishes certain conditions that allow for individualized services in situations when a provider "pools" funds to serve several customers in one setting. However, providers must contract and bill services separately. Under Section 309-041-1870 (7) (a) (A-E), a provider must also plan in a manner that allows any one customer to "pull away" at any time without jeopardizing the stability of the support committed to other support service customers. In other words, a provider organization should consider marketing strategies and rate structures that support continuation of enclaves for co-workers with disabilities or in home supports for roommates, even when one group member leaves.

3. Billing and Payment is Based on Distinct Services Delivered.

In order to be billed, individuals with disabilities must have directly received supports or work performed on their behalf to support billing. A provider cannot bill when someone does not show for or attend a scheduled activity. Providers can consider such situations when establishing a rate. (See examples in this manual).

A provider organization must present an itemized bill listing services actually provided for each customer. The itemized bill requires documentation of the dates of service, the type and units of service scheduled and delivered, the location of service, and the person(s) furnishing support. Two examples of billing forms are provided on pages 60 and 61of the manual.

A brokerage can operate as a fiscal intermediary and make payments on behalf of the individual with his or her authorization. Evidence of authorization may include the individual signing off on services or may occur as a result of PA follow-up with the customer.

Overall Recommendation: To meet the above requirements, provider organizations should maintain a separate tracking system for pricing, contracting and billing of individualized support services. This data will allow the organization to answer questions about rate setting and content, bill for services, complete internal reviews and evaluate the accuracy of their system.

Questions to Help Define Services and Service Units

At a minimum, a provider organization will want to answer the following questions in the process of identifying services they will offer to brokerage customers

1. **How do purchasable supports services match up with what is now available in our organization?**

   Full definitions of Support Services are provided on pages 64 to 67 of this manual. Organizations may choose to sell supports similar to those now available to persons in contracted slot-based services, or expand services consistent with supports allowed by the federal Center for Medicaid and Medicare Services (CMS) in the approved waiver document.

   In Self-Directed Support Services, providers will no longer be selling a predetermined package of services. They need to become comfortable talking not about programs, but what the customer wants that will support their individual plan. Table 5, Talking about Support Services provides descriptions of services from the perspective of all major stakeholders. Column 2 gives examples of what a person with disabilities may want and the traditional titles we have used for those supports.

2. **Who are the desired customers for our organization?**

   Organizations can choose the customer base to which they will market. An employment certified program could decide to only provide services to existing customers who will transition to self-directed support services in the 2003-2005 biennium. They could also decide to offer supports to the many new customers presently entering brokerages. These strategic decisions will depend upon an assessment of staff and organizational qualifications and priorities, matched against what customers want and need.

3. **What do we think customers will buy?**

   Table 5, Talking about Support Services, column 3, provides descriptions for most commonly purchased Supported Employment or Community Inclusion Services. Rate ranges will be established in each of these areas. It is still the responsibility of the provider organization to describe the distinct services for sale to potential customers.

   On Table 5, service titles (column 3) and billing titles for Medicaid (column 1) will not always match exactly. For example, on page 16 the suggested service title for buyers of support may be " inclusion skill training", the billable support service category used by the PA is "Community Inclusion", the provider may have another

title for the service. The blank Support Service Description Form includes lines for the Support Service Funding Category and for the User Friendly Service Title to help buyers and sellers understand one another's language.

4. What is the most reasonable unit of service, for the services we are interested in selling?

The unit of service is a discreet measure for service or product delivery. It is generally the basis for communicating costs. Table 5 summarizes the possible units of service an organization could use.

A provider organization should also consider other factors that may influence the chosen units of service. What would be understandable to the customer? What do other funders such as the Office of Vocational Rehabilitation Services and the Commission For the Blind require? What will be cost effective for the organization?

Table 4: Possible Units of Service

Unit of Service	Services Typically Based on This Unit
Hour *(Staff intervention time)*	Job Exploration, Job Development, or Job Coaching, Individualized Supported Employment, Community Living, or Community Inclusion, Respite
Day *Half day, weekend*	Respite, Group Employment or Community Inclusion Specified time period of activity or outing
Per Trip, per Mile	Transportation
Month	Use of this traditional unit may be cost effective for billing purposes. Whenever a monthly service unit is established, the provider organization is responsible for prorating billable services based on actual attendance
Package By Outcome or Performance	Some national experience for use of this model for supported employment. Limited Oregon experience makes it impossible to establish rate ranges for this year.

Note: A Day is 5 or more hours of goal related activity for customer.

The provider must track services based upon the delivery of a specified number of service units or partial units. Tracking will be required at the level of 1/2 the chosen unit of service. In other words, if the unit is one hour of 1:1 staff intervention, a provider will track each partial unit and may bill for 30 minutes or 1/2 an hour for portions of service. As noted in Table 4, a day unit must be 5 or more hours of activity available to the customer. The identification of a partial day will be based on 1/2 of the day (5 hour, 6 hour, 7 hour, etc.) defined by the provider. In no case will it be less than 2.5 hours.

5. Is our organization equipped to provide services and supports on short notice?

Brokerages will, in most cases, assist the individual to develop an annual person-centered plan and identify a provider to match person centered plan goals for all or part of the 12-month period. For some individuals, situations will arise and the Brokerage may be requesting that services be provided due to an emergency. In these cases, services may need to begin immediately, (in-home supports beginning tonight at 6PM) or may be for a limited time period (community inclusion support or respite for the period of time a care giver is in the hospital).

Provider organizations should identify their interest and ability to address emergency support requests. Requests of this nature may be an effective way to use a temporarily vacant bed in a residential site or vacant slot in an employment or ATE program. It may also provide opportunities to use qualified on-call or part-time staff.

6. How will our organization actually describe the services to be sold?

The service description is the basis for communicating with the individual, family, and brokerage about what they can purchase from a particular provider organization. The categories and definitions on Table 5 may be helpful, but you are not limited to these examples. A blank Support Service Description Form is provided on page 19 to assist in this process.