Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

State of Oregon, Department of Human Services

Submission Date:	June 29, 2006

CMS Receipt Date *(CMS Use)*	

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

Brief Description:
Oregon Department of Human Services (DHS) requests renewal of waiver #0185.90.R2 to continue long-term community-based services for individuals who are aged (age 65 and above) or physically disabled (age 18 or above). These services are administered by DHS, Oregon's single state Medicaid agency, through its Seniors and People with Disabilities (SPD) program.

Application for a §1915(c) Home and Community-Based Services Waiver

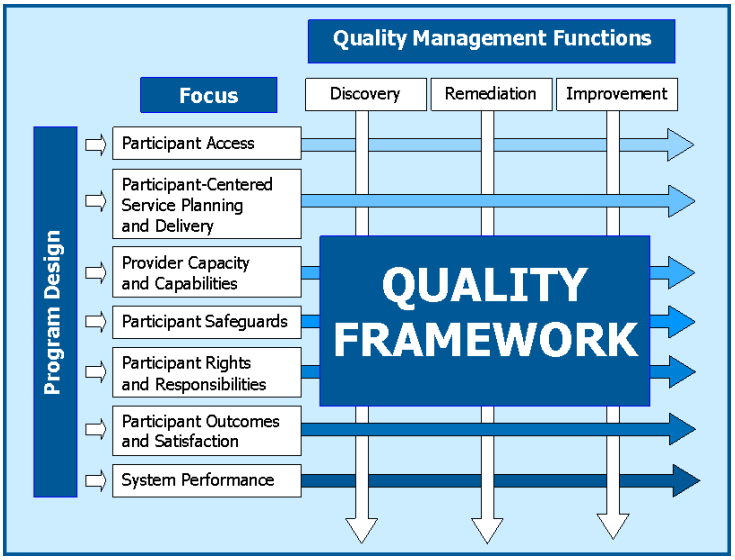
PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- **Participant Access**: *Individuals have access to home and community-based services and supports in their communities.*
- **Participant-Centered Service Planning and Delivery**: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
- **Provider Capacity and Capabilities**: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- **Participant Safeguards**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- **Participant Rights and Responsibilities**: *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- **Participant Outcomes and Satisfaction**: *Participants are satisfied with their services and achieve desired outcomes.*
- **System Performance**: *The system supports participants efficiently and effectively and constantly strives to improve quality.*



The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of Oregon requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (*optional*): Aged and Physically Disabled Waiver

C. Type of Request *(select only one)*:

○	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
X	**Renewal (5 Years) of Waiver #**	0185.90.R2	
○	**Amendment to Waiver #**		

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

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
X	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: October 1, 2006

E.2 Approved Effective Date *(CMS Use):*

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

☐	Hospital *(select applicable level of care)*
○	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

	○	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
X	Nursing Facility *(select applicable level of care)*	
	X	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
X	Not applicable			

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Purpose:

The Oregon Department of Human Services (DHS) operates Waiver #0185.90 to:

- Promote a service environment that values and fosters individual independence, dignity, privacy, and choice; and
- Support preferences of individuals who require nursing home level of care for long-term care services at home or in community facilities.

Goals and Objectives:

DHS will serve individuals in the least restrictive, most cost-effective community alternatives to nursing facilities, based on personal preferences and choice. Each year, DHS will provide services under the waiver to support:

- Nearly 30,000 adults aged 65 or over and adults with physical disabilities in services and settings they choose outside of nursing facilities and
- At least 15,000 of these adults in ways that allow them to remain at home or with family.

DHS will also maintain and improve opportunities for self-directed home and community based services. At least 13,000 individuals each year will direct the services that allow them to remain at home.

Organizational Structure

DHS is Oregon's single state Medicaid agency, responsible for administering and overseeing services throughout the state. Seniors and People with Disabilities (SPD) is the administrative unit within DHS assigned to provide leadership, regulate services, provide protective services, manage resources, and carry out DHS responsibilities related to Medicaid program participation in long-term care for individuals who are elderly or who are adults with physical disabilities.

Local case management entities are entry points for all services and perform standardized functions such as level of care assessment/reassessment, plan development, service authorization, service monitoring, and offer of choice between nursing home and community-based care. These local entities are either SPD field offices or Area Agencies on Aging (AAA's) performing according to OAR 411-002-0100 through 0175 and written agreements with SPD.

SPD contracts with qualified providers for the provision of waiver services.

Service Delivery Methods

All services are based on individual choice and participant-driven planning. SPD estimates 44% of individuals served under the waiver will choose more traditional service delivery methods in family-scale settings (Non-Relative Adult Foster Homes and Relative Adult Foster Homes), large facilities (Residential Care Facilities, Assisted Living Facilities), or small shared-attendant apartment settings (Specialized Living Services). SPD anticipates all other individuals will choose services that allow them to remain in their own homes (i.e. In-Home Services, Home Accessibility Adaptations, Community Transition Services, Home-Delivered Meals, Non-Medical Service Transportation, Adult Day Services). In-Home Services features participant direction as the primary service delivery method.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

X	The waiver provides for participant direction of services. *Appendix E is required*.
○	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed*.

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. **Appendix H** contains the Quality Management Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

○	Yes

X	No
○	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

○	**Yes** *(complete remainder of item)*
X	**No**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

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

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431
Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b)

individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

Opportunities for public input on service performance and continuing needs are not limited to this waiver renewal process. Self-advocates and community leaders were instrumental in developing an original vision of community-based alternatives to nursing home services that led to creation of Oregon's waiver service system in the 1980's. Consumer-based advisory groups are longstanding partners, as are groups representing providers and local governments, in revisiting the vision and establishing parameters for services. Several service developments and corresponding waiver amendments have had their roots in this public input over a long history with waiver services.

SPD intended to work with its Aging/Physical Disabilities Quality Assurance Committee (QAC) in preparation for the waiver renewal application. In August 2005, however, a work group of consumers, advocates, providers, and state and local government representatives---including several QAC members---began a planning process around the future of long-term care in Oregon that essentially placed QAC consideration of minor adjustments for this waiver application on hold (see http://www.oregon.gov/DHS/spwpd/ltc/fltc/index.shtml). The planning work group recently drafted recommendations around key questions addressing long-term service design and delivery, including Medicaid home and community based services as well as other resource and program options, but the planning process is not over. The next stage of the process is occurring now, as the Governor's Commission on Senior Services in partnership with SPD conducts community forums throughout the state May-June 2006 to share information and obtain further community input prior to developing a final report. Given the timing, SPD is not in a position to address, with this waiver renewal application, all the issues and ideas that will crystallize through planning activities over the next several months. The application does not propose any significant changes in service design or delivery, and SPD will work with its QAC on future waiver amendments as needed to implement legislative and administrative directives that arise from the current planning effort.

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

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

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	DeAnna
Last Name	Hartwig
Title:	Administrator, Office of Federal Resource and Financial Eligibility
Agency:	Department of Human Resources, Seniors and People with Disabilities
Address 1:	500 Summer St. NE, E-12
Address 2:	
City	Salem
State	OR
Zip Code	97301-0175
Telephone:	503 947-1180
E-mail	DeAnna.J.Hartwig@state.or.us
Fax Number	503 373-7902

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

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

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

Signature: Chyla Bark to Bruce Goldberg
State Medicaid Director or Designee

Date: 06/28/06

First Name:	Bruce
Last Name	Goldberg, M.D.
Title:	Director
Agency:	Department of Human Services
Address 1:	500 Summer St. NE, E-15
Address 2:	
City	Salem
State	OR
Zip Code	97301-0175
Telephone:	503 945-5944
E-mail	Bruce.Goldberg@state.or.us
Fax Number	503 378-2897

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable

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)*:

X	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)*:	
	X	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
○	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.*
X	**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)*:

X	**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:*
	Area Agencies on Aging (AAAs) meeting the definition of an area agency on aging and administered by a unit or combination of units of general purpose local government, which administers the Medicaid, financial and adult protective services, and regulatory programs of elderly or adults with physical disabilities. (These may also be referred to as "Type B" or "Transfer" AAAs in this document.)
☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
☐	**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:

The six-person Performance Evaluation Unit of SPD's Office of Licensing and Quality of Care reviews and monitors the accuracy and consistency of waiver operational and administrative functions performed by all local offices, including AAAs, through two ongoing processes:

a. In a two-year cycle, Performance and Evaluation Unit members conduct a field review, evaluating activities in all 57 local SPD and AAA offices against waiver requirements such as timeliness, accuracy, appropriateness of services, compliance with State and Federal regulation, program outcomes, consumer satisfaction and cost effectiveness. The process of

evaluation involves Performance Evaluation Unit examination of a sample of participant cases through review of data stored in electronic databases, review of case files on-site, and individual interviews that include an assessment of consumer satisfaction. The Performance Evaluation Unit records findings using a standard tool (tool and instructions available on request) and issues a formal finding in a report to the local office identifying policy and rule errors to be corrected. The local office must submit a plan of correction to SPD within 30 days of receipt of this report. SPD then issues a final report to the local office. SPD enters details of the review of each individual's record into the Quality Management Data Base (QMDB) for tracking. This process is a source of ongoing data about assistance with waiver enrollment, LOC activities, participant services plans, and prior authorization of waiver services. The process also provides information, through direct observation and review of factors associated with participant outcomes and satisfaction, that aids evaluation of other functions such as dissemination of information concerning the waiver to potential enrollees, recruitment of providers, conduct of utilization management functions and training/technical assistance concerning waiver requirements.

b. The Performance Evaluation Unit sends each local SPD and AAA office a yearly 1% random sample participant list for review by local offices using a standard survey form (the Quality Assurance Home and Community Based Care Case Review Checklist). This checklist records review of financial and service eligibility, participant preferences, risk monitoring, participant goals, contingency plans, signed plan of care and participant choice form. The local office managers are responsible for reviewing each case, documenting corrective actions and signing off on the review. The local office returns a finished survey form for each case reviewed to SPD for review, database entry, tracking and analysis. SPD staff compile this information into reports at least annually and more frequently as needed by SPD Management or the Quality Assurance Committee.

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	X	☐	☐	X
Assist individuals in waiver enrollment	X	☐	☐	X
Manage waiver enrollment against approved limits	X	☐	☐	☐
Monitor waiver expenditures against approved levels	X	☐	☐	☐
Conduct level of care evaluation activities	X	☐	☐	X
Review participant service plans to ensure that waiver requirements are met	X	☐	☐	X
Perform prior authorization of waiver services	X	☐	☐	X
Conduct utilization management functions	X	☐	☐	X
Recruit providers	X	☐	☐	X
Execute the Medicaid provider agreement	X	☐	☐	☐
Determine waiver payment amounts or rates	X	☐	☐	☐
Conduct training and technical assistance concerning waiver requirements	X	☐	☐	X

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Included	Target Group/Subgroup	Minimum Age	Maximum Age	
			Maximum Age Limit: Through age –	No Maximum Age Limit
○	**Aged or Disabled, or Both**			
X	Aged (age 65 and older)			X
X	Disabled (Physical) (under age 65)	18		
☐	Disabled (Other) (under age 65)			
	Specific Aged/Disabled Subgroup			
☐	Brain Injury			☐
☐	HIV/AIDS			☐
☐	Medically Fragile			☐
☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both**			
☐	Autism			☐
☐	Developmental Disability			☐
☐	Mental Retardation			☐
○	**Mental Illness**			
☐	Mental Illness (age 18 and older)			☐
☐	Serious Emotional Disturbance (under age 18)			

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

Not applicable

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

X	Not applicable – There is no maximum age limit
C	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

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)*:

X	**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 limit specified by the State is *(select one)*:
	○ The following dollar amount: $ _____
	The dollar amount *(select one)*:
	○ Is adjusted each year that the waiver is in effect by applying the following formula:
	○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
	○ The following percentage that is less than 100% of the institutional average: _____ %
	○ Other – *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Not applicable

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	29,089
Year 2	29,037
Year 3	28,982
Year 4 (renewal only)	29,033
Year 5 (renewal only)	29,085

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

X	The State does not limit the number of participants that it serves at any point in time during a waiver year.
○	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

X	**Not applicable**. The state does not reserve capacity.
○	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

X	The waiver is not subject to a phase-in or a phase-out schedule.
○	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

X	Waiver capacity is **allocated/managed*** on a statewide basis.
○	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

*The term "allocated/managed" is misleading here. Oregon has established a statewide unduplicated maximum number of individuals served under the waiver. We do not "manage" capacity by reallocation or shifting services around the state in response to local or regional enrollment.

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

SPD offers entry to the waiver to all persons in the target populations that meet financial criteria, meet criteria for Service Priority Levels 1-13, (specified in Oregon Administrative Rules (OAR) 411-015-0000 through 411-015-0100), and do not otherwise have natural supports available to meet assessed needs. SPD determines Service Priority Levels based on needs for assistance or full assistance in activities of daily living as assessed using the standardized Client Assessment and Planning System.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
		Waiver Year:	
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

○	§1634 State
X	SSI Criteria State
○	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)				
☐	Low income families with children as provided in §1931 of the Act			
X	SSI recipients			
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121			
X	Optional State supplement recipients			
☐	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*			
	○	100% of the Federal poverty level (FPL)		
	○	%	of FPL, which is lower than 100% of FPL	
X	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)			
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)			
☐	Medically needy			
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			
Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*				
○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.			

X	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5*.				
	○	All individuals in the special home and community-based waiver group under 42 CFR §435.217			
	X	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:			
		X	A special income level equal to (select one):		
			X	300% of the SSI Federal Benefit Rate (FBR)	
			○	%	of FBR, which is lower than 300% (42 CFR §435.236)
			○	$	which is lower than 300%
		☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)		
		☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)		
		☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)		
		☐	Aged and disabled individuals who have income at: *(select one)*		
			○	100% of FPL	
			○	%	of FPL, which is lower than 100%
		☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

X	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
	X Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.*
	○ Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one):*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○		%	of the Federal poverty level

	○	Other (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			

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

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

iii. Allowance for the family *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Other (specify):		
○	Not applicable (see instructions)		

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

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.

○	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ The following standard under 42 CFR §435.121:
    - [ ]
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one)*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ [ ] % of the FBR, which is less than 300%
    - ○ $ [ ] which is less than 300% of the FBR
  - ○ [ ] % of the Federal poverty level
  - ○ Other (specify):
    - [ ]
- ○ The following dollar amount: $ [ ] If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:
  - [ ]

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

- ○ The following standard under 42 CFR §435.121
  - [ ]
- ○ Optional State supplement standard
- ○ Medically needy income standard
- ○ The following dollar amount: $ [ ] If this amount changes, this item will be revised.
- ○ The amount is determined using the following formula:
  - [ ]
- ○ Not applicable *(see instructions)*

iii. Allowance for the family *(select one)*

- ○ AFDC need standard
- ○ Medically needy income standard

○	The following dollar amount: $ [ ] The amount specified cannot exceed the higher amount: of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
X	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	X	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one):*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.

	○	%	of the Federal poverty level
	○	Other (specify):	
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		

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

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
	○	SSI standard	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount: $	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
X	Not applicable		

iii. Allowance for the family *(select one)*:

X	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount: $	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.	
○	The amount is determined using the following formula:		
○	Other (specify):		
○	Not applicable (see instructions)		

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

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.

X	The State establishes the following reasonable limits *(specify)*:
	The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):

○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one)*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	
	○	Other (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			

ii. <u>Allowance for the spouse only</u> (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:			
	Specify the amount of the allowance:			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The following dollar amount:	$	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:		
○	Not applicable			

iii. <u>Allowance for the family</u> *(select one)*

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Other (specify):		
○	Not applicable (see instructions)		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
O	The State establishes the following reasonable limits *(specify)*:

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**			
○	SSI Standard		
X	Optional State Supplement standard		
○	Medically Needy Income Standard		
○	The special income level for institutionalized persons		
○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
O	The following formula is used to determine the needs allowance:		
O	Other (*specify*)**:**		

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*	
X	Allowance is the same
O	Allowance is different. Explanation of difference:
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:	
a. Health insurance premiums, deductibles and co-insurance charges. b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
O	The State does not establish reasonable limits.
X	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

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)*:	
	X	The provision of waiver services at least monthly
	○	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○	Directly by the Medicaid agency
○	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
X	Other (*specify*):
	Case managers in local SPD field office and Area Agencies on Aging are responsible for performing the evaluations and reevaluations.

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

All plans of care are developed and approved by qualified case managers. SPD's minimum case manager qualifications are:

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

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

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

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

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

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

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

Levels of Care are determined as a result of a comprehensive assessment, conducted by a case manager, using an electronic tool called the Client Assessment and Planning System (CA/PS). This assessment documents a person's abilities and limitations in areas of activities of daily living (ADL) and instrumental activities of daily living (IADL). It also collects information about living environments, personal characteristics and preferences, treatments and general health history. Using a programmed algorithm, CA/PS then calculates an individual's priority for receiving services based upon the degree of assistance an applicant requires with specific activities of daily living. This assessment tool is used to determine eligibility for home and community based care as well as nursing facility care.

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

X	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:

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

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
X	Every twelve months
○	Other schedule (*specify*):

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

X	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)*:

SPD sends each local SPD and AAA office a computerized list of names of individuals who must have an annual re-assessment within the next 90 days. The list includes case manager identification. Re-assessments for service eligibility must be done by the CA/PS review due date or SPD will suspend payment for individual and facility providers. An overdue assessment report is available from the mainframe reporting system "View Direct". The report WCM 0390-RA.

Effective July 1, 2006, SPD will send individuals due for re-assessments a minimum 14-day advance notice that a re-assessment is necessary before the end of the following month. Individuals may call to schedule their re-assessments.

The Oregon ACCESS CA/PS has Re-determination and Medical Review Due reports by

branch and worker codes. Local SPD and AAA offices have procedures in place to run these reports to meet the required review dates.

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:

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

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

Appendix B-7: Freedom of Choice

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

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

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

Local SPD or AAA case managers inform eligible individuals or their legal representatives of the choice of institutional or waiver services after determining eligibility and informing the individual/legal representative of feasible alternatives available under the waiver. Individual or legal representative choice of home and community-based services is documented by his or her signature on DHS form 914 at initial placement. The individual's case manager subsequently reviews freedom of choice with, and obtains documentation of choice from, the individual/legal representative:

- as requested;
- if a change in individual's condition indicates need for service change; or
- when there is a change in the individual's living situation.

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

Hard copies of DHS 914 are kept in the individual's file in local SPD or AAA offices. That file is transferred if the individual moves to another branch or county so the record of choice is available wherever the individual receives services.

Appendix B-8: Access to Services by Limited English Proficient Persons

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

When the caseload of a local SPD or AAA office consists of 35 or more non-English-speaking households which share the same language, Oregon Revised Statute 411.062 requires the Department of Human Services to provide, at that local office, written materials in that language and access to a bilingual assistance worker or caseworker fluent in both that language and English.

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

Many vital forms and notices (e.g. SDS 0539A-Application, SDS 0540-Notification of Planned Action with DHS 0447-Hearing Rights attached), SDS 0541-Notification of Approval with DHS 0447 attached), DHS 9001-Client Discrimination, DHS 1005-Alternate Format Notification, DHS 2099-Release of Health Information) are available for applicants and recipients in languages that are used by a significant number of individuals in the state. Most frequently, documents are translated into Russian, Vietnamese, and Spanish and are available on the Department's website or in hard copy at the local office.

Language assistance is available for telephone conversations through a contractor.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	☐	
Adult Day Health	**X**	Adult Day Services
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	☐	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
X	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Non-Relative Adult Foster Care

b.	Relative Adult Foster Care
c.	Residential Care Facilities
d.	Assisted Living Facilities
e.	Specialized Living Services
f.	Home Delivered Meals
g.	In-Home Services
h.	Home Accessibility Adaptations
i.	Non-Medical Service Transportation
j.	Community Transition Services

Extended State Plan Services *(select one)*

X	Not applicable
○	The following extended State plan services are provided *(list each extended State plan service by service title)*:

Supports for Participant Direction *(select one)*

X	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
○	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	

Other Supports for Participant Direction *(list each support by service title)*:

a.	
b.	
c.	

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c*.
X	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case managers are employed by either SPD in local Field Services offices or by SPD Area Agency on Aging (AAA) contractors.

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services *(select one)*:

X	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) Positions subject to required criminal history and background investigations. Oregon Revised Statute (ORS) 181.537 and OAR 410-007-0200 through 0370 authorize DHS to conduct reasonable screening to determine whether potential and current providers of waiver services have a history of criminal behavior such that they should not be allowed to oversee, live or work closely with, or provide services to vulnerable people. SPD conducts, or requires contractors to conduct, such criminal records checks on:

- Applicants for license as 24-hour community facility (i.e. Residential Care Facility, Non-Relative Adult Foster Care, Adult Relative Foster Care, Assisted Living Facility);
- Staff and volunteers of 24-hour community facilities, Adult Day Services, Specialized Living Services;
- Home Care Workers;
- Staff and volunteers of any other agency providing direct personal services (e.g. Non-Medical Transportation, Home Delivered Meals, personnel services or staffing agency) to waiver service recipients;
- Any other person licensed, certified, registered or otherwise regulated or authorized by DHS and who provides direct care; and
- Persons authorized by DHS to receive and process criminal history information and conduct fitness determinations.

(b) Scope of investigations. All screenings include information obtained from the Oregon State Police Law Enforcement Data System, but DHS obtains from other sources and states the information necessary to complete the work. For example, DHS may require a national search using fingerprints and the FBI database under several circumstances, e.g.: out-of-state residency for 60 or more consecutive days during the previous three years; indication of criminal history outside Oregon; or there is some question of identity or history. DHS-authorized designees make final fitness determinations using a weighing test based on law enforcement data provided from the DHS Criminal Records Unit concerning past arrests and convictions as well as mitigating circumstances (e.g. rehabilitation, diversion, time passed since conviction or arrest). Criminal background screenings are typically conducted prior to execution of provider agreements and at intervals thereafter based on rules for the service provided and at any time DHS has reason to believe that re-screening is required. For example, the criminal history clearance process for a Home Care Worker (provider of In-Home Services) must involve an initial fitness determination and subsequent re-screening every other year, with additional reviews as needed, by an authorized designee in a local SPD or AAA office.

(c) Process for ensuring mandatory investigations have been conducted according to policy. The DHS Criminal Records Unit (CRU) has developed standard forms and processes to initiate and conduct criminal background screening. The CRU approves all persons authorized by DHS ("authorized designees") to conduct screenings based on criminal background checks and satisfactory completion of CRU-provided training on standard forms, processes, information sources and implications, and factors to consider in weighing tests. Additionally, provider payment is linked to continued compliance with criminal history review standards, e.g.:

- Local SPD or AAA workers authorize payment to Home Care Workers based on initial fitness determination and must enter re-approval at prescribed intervals or provider payment is suspended and
- Licensed provider enrollment payment is suspended when license expires unless SPD worker enters information that license has been renewed. Licensing process involves sampling personnel files for evidence criminal background review and fitness determinations according to DHS policy.

○ **No**. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

○	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
X	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

○	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
X	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Non-Relative Adult Foster Care	Supervision and assistance 24-hours/day to support individual health, activities of daily living and instrumental activities of daily living. The personalized services are designed to: 1) help individuals develop skills to increase or maintain level of functioning and 2) encourage maximum independence and enhance quality of life.	5 individuals: unrelated by blood or marriage to foster provider; elderly or have disabilities; and receive care
Residential Care Facilities	Supervision and assistance 24-hours/day to support individual health, activities of daily living and instrumental activities of daily living. Services are provided in shared or individual living units where six or more seniors or adults with disabilities may reside. Services address personal assistance, health and social needs in ways that promote choice, dignity, individuality and independence.	none
Assisted Living Facilities	Supervision and assistance to support individual health, activities of daily living or instrumental activities of daily living---coordinated or provided as needed in support of individual preferences and comfort in fully self-contained private living settings. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.	none

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Non-Relative Adult Foster Care: Services are provided in settings of five or fewer individuals in care in a single home and must be appropriate to the needs, preferences, age and condition of the individual residents. These homes are generally indistinguishable from their neighbors in communities throughout the state. Cooking, dining, and common areas are typical in scale and use of family homes in the area, with access limited only by specific individual resident safety concerns. No more than two residents share a bedroom. Treatment and care activities are conducted privately. Residents associate and communicate privately with any person of choice. Providers are required to make available at least six hours of activities each week oriented to individual interests, not including television and movies. Residents also have access to, and participate in, activities of chosen social, religious and community groups.

Assisted Living Facilities: Administrative rules under which Assisted Living Facilities are regulated require each facility to deliver services and design the physical environment in ways that support resident dignity, independence, individuality, privacy, choice and decision-making abilities. "Home" in these rules is defined as a living environment which creates an atmosphere supportive of the resident's preferred lifestyle and is supported by the use of residential building materials and furnishings. Personalized care is furnished to individuals who reside in their own living units which are separate and distinct from each other. Units may be dually occupied only when both occupants consent to the arrangement. Units include kitchenette and/or living rooms as well as bedrooms and toilet facilities. Resident laundry facilities, unit mailboxes, and telephone lines in each unit are provided. Personal living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms).

Residential Care Facilities: Residential Care Facilities provide a wide range of services in a shared, homelike environment designed to enhance the dignity, independence, individuality, and decision-making ability of the residents in a safe, secure environment. Resident units may be comprised of individual apartments with private bathroom and kitchenette. If resident units are limited to private or semi-private bedroom only, then bathroom facilities are centrally located off common corridors. In all cases, separate wardrobe closets are provided for each resident's clothing and personal belongings. Separate resident laundry facilities have been provided in all facilities licensed on or after January 1, 1994, allowing residents to schedule use for personal laundry. If phones must be located in a staff area, the phone must be available for normal resident use at any time and ensure resident privacy during the call. Common dining and living areas are furnished in a homelike manner. An accessible outdoor recreation area is required and must be available for all residents to use.

In all settings, routines of care and service delivery must be consumer-driven to the maximum extent possible. Social and recreational activities based on individual and group interests that create opportunities for active participation in the community at large must be provided.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type: Adult Foster Care	Facility Type: Residential Care Facility	Facility Type: Assisted Living Facility
Admission policies	X	X	X
Physical environment	X	X	X
Sanitation	X	X	X
Safety	X	X	X
Staff: resident ratios	X	X	☐
Staff training and qualifications	X	X	X
Staff supervision	X	X	X
Resident rights	X	X	X
Medication administration	X	X	X
Use of restrictive interventions	X	X	X
Incident reporting	X	X	X
Provision of or arrangement for necessary health services	X	X	X

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

OAR 411-056-0018 requires the Assisted Living Facility to "have qualified staff sufficient in number to meet the 24-hour scheduled and unscheduled needs of each resident and respond to emergency situations". Overall staffing ratios have not been prescribed for Assisted Living Facilities because residents are typically independent in many areas, with needs varying from site to site, and so the minimum number of staff required to meet resident needs at all sites is not predictable. If the facility is not meeting the needs of the residents, either by failing to provide scheduled services or to respond to emergencies, SPD determines staffing to be inadequate. SPD is made aware of issues that might lead to this determination primarily through: 1) case manager monitoring of individual plan implementation; 2) surveyor observations and other data collected during licensing reviews; and 3) protective services activity.

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of

personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

○	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
X	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

a) **Legally responsible individuals and services furnished:** Spouses of service recipients may be paid to furnish In-Home Services (see service description in C-3).

b) **Oregon policies specifying circumstances and how provision by legally responsible individual is in best interest of service recipient:** Provision of In-Home Services by the spouse of a service recipient is considered when the service recipient has chosen to receive In-Home Services and expressed a preference for the spouse to be the provider of these services. Spouse enrollment and payment as a provider, however, is only allowed if:

- The service recipient's needs for extraordinary care exceed in both extent and duration the usual and customary services rendered by one spouse to another. To assist in making this determination, the local SPD or AAA Case manager reviews the needs and conditions of the spouse and must confirm that the service recipient requires full assistance in at least four of six activities of daily living and has medically diagnosed progressive debilitating condition which will limit additional activities of daily living, or has experienced a spinal cord injury or similar disability with permanent impairment of the ability to perform activities of daily living **AND**
- A second, independent assessment is completed by a Pre-Admission Screening specialist that confirms the need for full assistance in four of six activities of daily living **AND**
- The service recipient's spouse demonstrates capability and health to provide services and actually provides the principal care (at least 51% of all care hours) for which payment has been authorized.

A program analyst in the SPD Central Office must review this information and approve initial requests for the program. Case managers send yearly reapplications for Central Office review.

Case managers fully inform service recipients of the option to choose providers other than the spouse prior to entering into spousal pay arrangements. The discussion also addresses minimum qualifications (the spouse is subject to the same minimum qualifications as other In-Home service providers) and the spouse's capacity to sustain the role of principal care provider. Once the service recipient has made the choice of spouse as provider, the Case manager monitors plan services and will revisit the decision with the service recipient if concerns arise.

c) **Controls employed to ensure payments made only for services rendered:** Payment is made to the spouse at live-in service rates based on the equivalent of one-half of the 24-hour availability and self-management task hours. SPD does not make additional payment for respite care and pays for an additional provider only by the hour and then only if the service recipient has specific needs that the spouse cannot meet alone (such as a two-person lift required for transferring or bathing).

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians**. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.

○	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
X	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives or legal guardians may be paid for providing three types of waiver services: In-Home Services, Non-Medical Service Transportation and Adult Relative Foster Care (see waiver services descriptions in C-3).

Limitations on the types of relatives/legal guardians who may furnish services:

In-Home Services and Non-Medical Service Transportation. Limits on payment of spouses are indicated in C-2-d. There are no limits on other types of relatives or legal guardians if all of the following are true:

- The service recipient has expressed a preference for either as a provider;
- The waiver services do not replace the natural supports provided by the relative/legal guardian;
- The relative/guardian meets minimum requirements for provider enrollment indicated in OAR 411-031-0040(8); and
- The service recipient lives in his or her own home and is not either in the home of the relative/legal guardian for the purpose of receiving care or living in a residential setting that must be licensed as a Relative Adult Foster Home.

Relative Adult Foster Care. The relative paid to provide care to a service recipient must be related by blood or marriage, although not the spouse of the service recipient. The relative providing care must be an adult and is required to clear DHS criminal history check, obtain a physician's statement of health, demonstrate understanding of the service recipient's care needs, obtain any necessary training to meet those needs, and meet fire safety compliance criteria.

In any service, Case managers fully inform service recipients of other service and provider options. Once the service recipient has made the choice of relative or legal guardian as provider, the Case manager monitors plan services and will revisit the decision with the service recipient if concerns about care or provider exercise of undue and harmful influence arise.

Controls employed to ensure that payments are made only for services rendered:

In-Home Services or Non-Medical Service Transportation: Amount of services is limited to hours authorized in the service recipient's annual service plan; assistance with ADL or self-management tasks and 24-hour availability cannot exceed maximum monthly hours indicated in OAR 411-030-0070. Local SPD or AAA Case managers authorize the payment system to issue vouchers for each provider no more than a month of service at a time. After services are provided, both provider and service recipient submit written confirmation on the voucher that services have been provided and the provider must send the completed voucher showing hours worked to the service recipient's Case manager. The case manager authorizes release of payment based on this evidence of service provision as well as any other information or observations obtained through routine service monitoring. The local SPD or AAA office keeps vouchers for reference and will initiate adjustments in services authorized if review indicates irregularities or services are not required for the tasks and in the amounts originally authorized. Participants or homecare workers who sign vouchers for work not performed are subject to prosecution for Medicaid fraud. This is also cause for the termination of the homecare worker's provider number so that they may no longer be paid by SPD. Several computer-generated reports also aid local offices and case managers in tracking if there are no services provided, e.g. a View Direct Report SJF0810R-Potentially Ineligible Clients No Waiver Services Received can be generated. This report runs 3 months behind as it checks which participants have paid in for services, received no services and therefore are being refunded their payment. (The 3-month delay lessens false positives since some homecare workers may not send their vouchers in promptly.)

Relative Adult Foster Care: The service recipient's case manager initially evaluates the natural support available in the relative home setting. The case manager assesses whether natural supports are already meeting all of the service needs, if the current provider(s) of natural supports are physically able and have time available to meet the service needs, and if natural supports would continue without payment. This initial assessment is reviewed at least annually and more often if need arises. Initial and annual licensing reviews are also opportunities to confirm that services provided are consistent with paid services.

○ Other policy. *Specify*:

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

Non-Relative and Relative Adult Foster Care. Persons interested in starting a foster care home may contact their local SPD or AAA office. Local office contact information is available at (www.oregon.gov/DHS/spwpd/offices.shtm) through links on the SPD website. The requirements, procedures and timeframes to qualify are listed in regulations online at (www.dhs.state.or.us/policy/spd/home.htm#rules) and reached through the Provider Tools section of the SPD website. SPD Central Office and local SPD and AAA offices also have hard copies of these that can be mailed to potential providers on request.

In-Home Services Homecare Workers. The state SPD website includes a link to Provider Tools (www.oregon.gov/DHS/spd/provtools/) which offers access to rules for Homecare Workers and a guide that explains how to qualify as a home care provider and enroll in the program. SPD Central Office and local SPD and AAA offices also have hard copies of these that can be mailed to potential providers on request.

Assisted Living and Residential Care Facilities. SPD placed a moratorium beginning August 16, 2001 on construction of new residential care and assisted living facilities due to overcapacity throughout the State. To date, SPD has not received complaints of inability to access these services from any Medicaid recipients. However, potential providers may seek exception to the moratorium by demonstrating that a service area is underserved using a current market analysis completed by a third party professional that validates that assertion. Information about this process, as well as requirements, procedures and timeframes for qualifying and enrolling as a provider, are available on the state SPD website in both the assisted living or residential care administrative rules (accessed through the link noted above). SPD Central Office and local SPD and AAA offices will mail copies on request.

Specialized Living Services. Information about requirements, procedures and timeframes for qualifying and enrolling as a provider are available on the state SPD website in administrative rules accessed through the link notes above. SPD Central Office and local SPD and AAA offices also have hard copies of these that can be mailed to potential providers on request.

Adult Day Services. Rules for registering as an adult day services provider can be located through the state website indicated above. SPD Central Office and local SPD and AAA offices also have hard copies of these that can be mailed to potential providers on request.

Non-Medical Service Transportation: Individuals may choose to have their Homecare Workers who provides In-Home Services also provide Non-Medical Service Transportation. Processes for willing and qualified providers to enroll as Homecare Workers are described above.

Home Accessibility Adaptations and Community Transition Services: Providers are community retailers, building contractors, or other entity capable of providing the work or goods at the lowest of three estimates obtained by the local SPD or AAA Case manager.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification

Service Title:	Non-Relative Adult Foster Care

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

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

Service Definition (Scope)**:**

Supervision and assistance 24-hours/day to support individual health, activities of daily living and instrumental activities of daily living. The personalized services are designed to: 1) help individuals develop skills to increase or maintain level of functioning and 2) encourage maximum independence and enhance quality of life. Services are provided in a licensed private home by a principal care provider who lives in the home. Non-Relative Adult Foster Care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including those receiving waiver services) living in the home and who are unrelated to the principal care provider, cannot exceed five.

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

Separate payment is not made for homemaker or chore services .

Provider Specifications

Provider Category(s) *(check one or both)***:**	**X**	Individual. List types:	☐	Agency. List the types of agencies:
	Non-Relative Adult Foster Care provider			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Non-Relative Adult Foster Care provider	Oregon Administrative Rules (OAR) 411-050-0400 through 0490		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Non-Relative Adult Foster Care provider	Local SPD field offices and Area Agencies on Aging	Initial license, renewals every 12 months.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	Relative Adult Foster Care

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

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

Service Definition (Scope)**:**

Supervision and assistance 24-hours/day to support individual health, activities of daily living and instrumental activities of daily living. Services are provided in the licensed private home where care is provided by a relative who lives in the home to one or two adult family members who are elderly or physically disabled. Relative Adult Foster Care is furnished to adults in conjunction with residing in the home. Care and services are intended to maintain or increase level of function, encourage maximum independence, and address the safety needs of the resident.

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

Provider Specifications

Provider Category(s) *(check one or both)***:**	**X**	Individual. List types:	☐	Agency. List the types of agencies:
	Relative Adult Foster Care Provider			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	**X**	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Relative Adult Foster Care Provider	OAR 411-050-0400 through 0490		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Relative Adult Foster Care Provider	Local SPD offices and Area Agencies on Aging	Initial license, renewals every 12 months

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X** Provider managed

Service Specification

Service Title:	Residential Care Facilities
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Supervision and assistance 24-hours/day to support individual health, activities of daily living and instrumental activities of daily living. Services are provided in shared or individual living units where six or more seniors or adults with disabilities may reside. Services address personal assistance, health and social needs in ways that promote choice, dignity, individuality and independence. Room and board costs are not included in waiver services.

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

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	**X**	Agency. List the types of agencies:
				Residential Care Facilities

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Residential Care Facility	OAR 411-055-0000 through 0280		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Residential care Facility	SPD Client Care Monitoring Unit (CCMU)	Initial license, renewal every two years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

Service Title:	Assisted Living Facilities
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.

○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Supervision and assistance to support individual health, activities of daily living or instrumental activities of daily living---coordinated or provided as needed in support of individual preferences and comfort in fully self-contained private living settings. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Services are provided in conjunction with residing in the facility. Routines of care provision and service delivery are consumer-driven to the maximum extent possible. Services do not include 24-hour skilled care or supervision.

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

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	**X**	Agency. List the types of agencies:
				Assisted Living Facilities

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Assisted Living Facility	OAR 411-056-0000 through 0095		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Assisted Living Facility	SPD Client Care Monitoring Unit CCMU)	Initial license, renewal every 2 years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

Service Title:	Specialized Living Services

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

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

Service Definition (Scope)**:**

Specialized Living Services are support and assistance with activities of daily living and instrumental activities of daily living, provided to individuals who cannot live independently or be served in other community-based facilities. Services are provided through a shared-attendant model to individuals

living in private residences located in apartment complexes or otherwise in close proximity to each other. Specialized Living Services are directed to helping service recipients toward more independent living.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				SPD Specialized Living Services (SLC) Contract Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
SLC Contract Provider			OAR 411-065-0000 through 0050 and SPD/Provider contract specifications

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
SLC Contract Provider	Local SPD and AAA offices	Prior to executing contract; reviewed annually thereafter

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification

Service Title:	Home Delivered Meals

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

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

Service Definition (Scope)**:**

Home Delivered Meals are provided for participants who live in their own homes, are home-bound, unable to do meal preparation, and do not have another person available for meal preparation. Provision of the home delivered meal reduces the need for reliance on paid staff during some meal times by providing meals in a cost-effective manner.

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

Home Delivered Meals are provided no more than once per day and contribute no more than an estimated one-third of the recommended daily nutritional regimen, with appropriate adjustments for weight and age.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	**X**	Agency. List the types of agencies:	
				AAA/Local senior service program	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian	

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
AAA/Local senior service program			OAR 411-040-0000

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
AAA/Local senior service program		

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

Service Title:	In-home Services

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

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

Service Definition (Scope)**:**

In-home services include ADL care (i.e. eating/nutrition, dressing, bathing/personal hygiene, mobility, bowel and bladder care, and behavior plan and IADL care (i.e. medication management, transportation, meal preparation, shopping, laundry, and housekeeping). Services are provided in the residence of the individual. In-home services may be provided on an hourly or live-in basis.

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

Payment for board and room is specifically excluded. Unless exceptional need has been established and new limits approved for an individual by SPD Central Office committee per OAR 411-027-000 through 411-027-0050, maximum monthly hours for assistance with activities of daily living and self-management tasks are subject to limits indicated in OAR 411-030-0070 and based on assessed level of assistance required.

Provider Specifications

Provider Category(s) *(check one or both)*:	**X**	Individual. List types:	**X**	Agency. List the types of agencies:	
	Home Care Worker			In-Home Care Agency	
	Spousal Pay				
Specify whether the service may be provided by *(check each that*	**X**	Legally Responsible Person	**X**	Relative/Legal Guardian	

applies):				

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Care Worker			OAR 411-031-0020 through 0050; OAR 411-030-002 through 0090
In-Home Care Agency	OAR 333-536-0000 through 0100		OAR 411-030-002 through 0090
Spousal Pay			OAR 411-031-0020 through 0050; OAR 411-030-002 through 0090

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Care Worker	Local SPD offices and Area Agencies on Aging	Initial authorization; criminal history re-checks every 2 yrs
In-Home Care Agency	SPD Central Office	Execution of contract
Spousal Pay	Local SPD offices and Area Agencies on Aging	Initial authorization; criminal history re-checks ever 2 yrs

Service Delivery Method

Service Delivery Method *(check each that applies)*:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

Service Title:	Adult Day Services

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

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

Service Definition (Scope)**:**

Services furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. A noon meal and snacks are provided to service recipients present during hours when similar meals and snacks would normally be served in the general community, but do not constitute a "full nutritional regimen" (three meals per day). Adult day services are community-based group programs designed to meet the needs of adults with impairments through individual plans of care. Professional assessment and therapy provided through the State Plan may be conducted on site, coordinated with waiver services through individual adult day service plans.

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

Does not duplicate authorized In-Home Services, Non-Medical Service Transportation, or Home Delivered Meals

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	**X**	Agency. List the types of agencies:
				Adult Day Services Providers

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult Day Services Provider			OAR 411-066-0000 through 411-066-0020

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Day Health Provider	SPD Central Office	Provider agreement execution, renewal every two years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

Service Title:	Home Accessibility Adaptations

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

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

Service Definition (Scope)**:**

Adaptations to a home owned by, and the primary residence of, a service recipient that may include installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies. All services are provided in accordance with applicable State or local building codes.

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

An adaptation may be purchased when the need arises, but only once, e.g. a ramp at one time, widening doorways another time, etc. Payment is limited to the lowest possible cost that will provide adequate facilities, based on three competitive bids (unless there are not three providers of the service in the local area). Excluded are adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are also excluded from this benefit.

Provider Specifications

Provider Category(s)	☐	Individual. List types:	**X**	Agency. List the types of agencies:

(check one or both):		Building materials retailer/contractor			
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian	

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Building materials retailer/contractor			OAR 461-155-0551

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Building materials retailer/contractor	Local SPD offices and Area Agencies on Aging	Prior to authorization of service and payment

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification

Service Title:	Non-Medical Service Transportation

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

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

Service Definition (Scope)**:**

Non-Medical Service Transportation is provided to eligible individuals to gain access to waiver community services, activities and resources.

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

Trips are related to recipient service plan needs, not for the benefit of others in the household, and are provided in the most cost-effective manner that will meet needs specified on the plan. Non-Medical Service Transportation waiver services are not used to: 1) replace natural supports, volunteer transportation, and other transportation services available to the individual; 2) obtain items that can be delivered by a supplier or by mail-order; or 3) compensate the service provider for travel to or from the service provider's home.

Provider Specifications

Provider Category(s) *(check one or both)*:	**X**	Individual. List types:	**X**	Agency. List the types of agencies:
	Home Care Workers		Local Transportation Authorities	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	**X**	Relative/Legal Guardian (Home Care Worker only)

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Care Worker			OAR 411-031-0020 through 0050
Local Transportation Authorities			SPD/provider contract specifications

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Care Worker	Local SPD offices and Area Agencies on Aging	Initial authorization
Local Transportation Authorities	SPD Central Office	Provider agreement execution, renewal every two years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	**X**	Participant-directed as specified in Appendix E	**X**	Provider managed

Service Specification	
Service Title:	Community Transition Services

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

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

Service Definition (Scope)**:**

Community Transition Services assist eligible individuals to return to their own homes or apartments from nursing facilities or from inpatient acute hospital stays. Assistance is in the form of payments for moving expenses such as: security deposits required to obtain a lease on an apartment or home; essential furnishings to establish basic living arrangements (e.g. bed, table, chairs, window blinds, eating utensils, and food preparation items); set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); and health and safety measures such as pest eradication, allergen control, or cleaning prior to occupancy.

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

This is a one-time service. Payment is authorized only for the minimum amount necessary to establish the participant's basic living arrangement. Services do not include rent for housing or temporary housing, ongoing utility costs, medical supplies such as reachers, grabbers, wheelchairs, and transfer trays, or recreational items such as a television or cable television access.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	**X**	Agency. List the types of agencies:
				General business provider
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
General business provider			OAR 461-155-0526

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
General business provider	Local SPD field offices and Area Agencies on Aging	Prior to authorizing service and payment

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	**X**	Provider managed

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*.
	SPD sets limits established by administrative rule. If needs exceed rule limits, individuals may apply for rate exception under Oregon Administrative Rule 411-027-0050 Exceptions to Payment Limitations in Community-Based Care.
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above*.
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*.
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
X	**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:	Plan of Care

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)
X	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
	Bachelor's degree in a Behavioral Science, Social Science, or a closely related field; **OR** Bachelor's degree in any field and one year of human services related experience (i.e., work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house); **OR** Associate's degree in a Behavioral Science, Social Science or a closely related field **AND** two years of human services related experience (i.e. work providing assistance to individuals and groups with issues such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate housing); **OR** Three years of human services related experience (i.e., work providing assistance to individuals and groups with issues such as economically disadvantaged , employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate housing).
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

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

X	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*:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) Supports and information made available to the participant (and/or family or legal representative, as appropriate). At intake, local SPD and AAA case managers inform individuals (and/or family or legal representative, as appropriate) of all types of public assistance and services. Case managers are expected to provide information and assistance to individuals to understand the range of long term care services available and to assist the individual to select options that meet the individual's needs. Case managers usually provide this information through discussions with individuals but also direct individuals to web resources and printed materials. One of the primary web resources is a DHS-sponsored web site, developed and maintained in conjunction with Oregon's Area Agencies on Aging, called Network of Care (http://oregon.networkofcare.org/index2.cfm?productid=1&stateid=43). Network of Care is an extremely user-friendly website that provides access to a vast range of services, assistive devices and equipment and a library of medical information to assist participants and case managers in case planning. In addition, SPD makes printed guides and brochures, such as the Oregon Consumer Guide to Assisted Living Facilities and Residential Care Facilities and A Guide to Oregon Adult Foster Homes directly available to potential residents, family members and friends on the web at http://www.oregon.gov/DHS/spwpd/ltc/ltc_guide/resources.shtml. Case managers may also print and provide this material. Local SPD and AAA offices also offer their own material on selecting a long term care option or on local resources.

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

(b) Participant's authority to determine who is included in the process. The individual or legal representative ultimately decides who may or may not be included in plan development discussions and contribute to the individual's plan of care. Recent administrative rule changes have strengthened and formalized participant's rights in this area, including that participants have the right to have natural support providers present at any assessment. The local SPD and AAA case managers will assist the individual in selecting and notifying other participants in the assessment and planning process. SPD also assists the individual through electronic notification 45 days in advance of the date due for annual LOC re-assessment and review of plan of care so that there is time to notify and prepare other participants.

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):

Local SPD and AAA case managers have the responsibility for assessing the individual's level of care and developing a plan of care in accordance with the individual's choice of services to be provided. The case manager must address all of the met or unmet needs of the participant through the assessment and provide the participant and the community-based facility with a copy of the plan of care for signature by all parties for the authorized services. The case manager will consult with service providers to review and verify the appropriate services are being offered and performed.

SPD relies on the local SPD and AAA case management system and its electronic tool for collecting, storing and summarizing service recipient information for service plan development. These are the essential resources featured in the answers to the questions in this section:

- Case management. Oregon's success in developing community-based care for seniors and people with disabilities has been built on its case management system. Long-term care service recipient quality of life depends on good planning and designing supports appropriate to needs. Service recipients and their families or legal representatives (as appropriate) in every community in Oregon access local case managers for information and referral, standardized assessment, and assistance with service planning and coordination.

- CA/PS. The Client Assessment and Planning System (CA/PS) is case management's basic tool for determining level of care and service priority, recording assessments, and establishing a central plan of care for each service recipient. It combines mobile technology that allows case managers to enter and retain comprehensive assessment information and to build the plan with the individual immediately on-site. The instrument is available for review on request.

(a) Who develops the plan, who participates in the process, and what is the timing of the plan? Case managers meet with each individual (and family or legal representative, as appropriate) at a schedule that will complete eligibility determination and an initial plan of care within 45 days of request for services. An in-home service plan is implemented when a provider is identified, the provider's service start date is set and the maximum hours of services have been determined. A plan for facility services is implemented as soon as the individual chooses and moves into a provider community-

based facility. The individual has the right to request changes in provider and living situation and a change in plan will be implemented as soon as an alternate plan can be implemented. Case managers will meet again with the individual (and family or legal representative, as appropriate) at least annually to review the plan of care. Other persons, as requested by the individual (or legal representative), may contribute to the development of this plan as well. Service providers may be included in both the assessment of needs and the plan development, if appropriate. All individuals who received waiver services must have an individualized plan of care developed annually and updated as needed. Each plan includes the type of service to be provided, the amount, frequency and duration of each service, the type of provider to furnish each service and the person responsible for carrying out the service. Since the plan is built in conjunction with the assessment of needs, it may develop simultaneously with determination of level of care and eligibility for waiver services. The plan of care may be developed shortly thereafter if the participant needs more time to consider service options or research on available options is necessary. In addition, plans are flexible and change to address emerging participant needs and preferences.

(b) What types of assessments are conducted to support the service plan development process, including information about participant needs, preferences and goals, and health status? Local SPD or AAA case managers conduct an assessment using the CA/PS tool, which prompts the case manager to have a comprehensive discussion with the participant about the participant's functional abilities and strengths in completing activities of daily living and instrumental activities of daily living. Discussion also includes psycho-social elements and the availability of natural supports to assist in meeting needs. CA/PS also includes optional resources for assessing participant abilities such as the Mini-Mental Status Exam for cognition and the Timed Up & Go test for mobility. Case managers must inquire and identify risks such as environmental hazards that may jeopardize safety or health. For participants living at home or in some foster homes, case managers gather information about emergency plans in the event of a natural disaster. (Administrative Rules require facility providers to prepare emergency plans for response to natural disasters.) If health concerns come to the case manager's attention through observation or discussion, the case manager assists the participant to access health services or necessary medical supplies. Case managers may also refer participants for Contract Registered Nurse services, including delegation of some nursing tasks and teaching, training and monitoring on a variety of health-related topics. When a participant resides in a community-based care facility, the case manager will meet with the participant, review the facility service plan and meet with facility staff to gain information about participant service needs.

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

(d) How does the plan development process ensure that the service plan addresses participant goals, needs (including health care needs), and preferences? CA/PS has mandatory fields to be completed for ADL needs to determine eligibility. Each ADL and IADL has identified fields for preferences to be recorded regarding the individual's choice on how these services are to be provided. Additional preferences may be documented on each screen of the assessment in a comments section. CA/PS has a section to record the individual's goals as they relate to quality of life, health, and/or living situation as stated in the participant's own words.

(e) How are waiver and other services coordinated? The case manager develops the plan of care with the participant/legal representative. The case manager is aware of services available and discusses service options with the participant. After the plan is implemented, case managers communicate with participants and providers as needed in order to oversee the coordination of services. Case managers contact participants and providers by phone, mail, or in person in the care setting to address service delivery issues. Plan monitoring is the primary tool for coordination of the services in the plan.

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

SPD Central Office program specialist train case managers to identify existing social networks or natural supports (such as friends and family) and non-Medicaid community programs, services and resources (such as Older Americans Act services) in the plan of care. Case managers provide information and/or assist participants to access these services and coordinate these resources with the rest of the plan. Case managers use CA/PS to document use of other resources.

Local SPD and AAA case managers coordinate services for participants who reside in facilities in cooperation with facility staff. The case manager communicates with staff and may participate in care conferences at the facility.

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

- For services provided to a recipient who lives at home, the local SPD or AAA case manager consults with the participant and provider to initiate service delivery, monitor for any change in care needs, and ensure the individual receives necessary supports. The case manager provides a task list for the individual and provider to use to self-monitor type and amount of services authorized. Payment vouchers are signed by the individual and the Homecare Worker to confirm the monthly service hours provided. The Homecare Worker returns signed vouchers to the local office for review before payment is authorized.
- In a licensed community facility, the case manager reviews the facility service plan and may participate in regularly scheduled care planning conferences.

Plans for recipients of In-Home services, Non-Relative Adult Foster Care, and Adult

Relative Foster Care may specify monitoring of participant care by a Registered Nurse under contract with SPD if referred by the SPD or AAA case manager. In these instances, the Contract RN may provide health monitoring, consultation with the physician and teaching to the participant and care provider. They may also provide the delegation of nursing tasks to a care provider. The plan of care identifies the service provider and the type and frequency of the service authorized by the case manager and agreed to by the individual.

The case manager assigned the ongoing service case has the responsibility to document in CA/PS any risks or potential risks to the individual's health and safety identified in the assessment. The case manager has the responsibility to document monitoring activities related to identified or reported health and safety concerns.

(g) How and when is the plan is updated, including when the participant's needs change? The plan is updated at least annually and more frequently with changes in a service recipient's condition or living situation. Sometimes a case manager schedules an earlier reassessment review date when a service recipient's condition or care setting is expected to change. The participant has the right to request changes in provider and living situation and a change in plan will be made as soon as an alternate provider or living situation can be obtained. The case manager updates CA/PS with new information and a plan for meeting new or changing needs.

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.

Health risks. During initial plan of care development and subsequent reviews, the individual's case manager conducts an assessment using the CA/PS tool to review risk factors for health and protective services with the individual, to offer resources to the individual and to plan appropriate safeguards. (Relevant portion of CA/PS assessment available on request.) If the case manager identifies health or medication risks to a recipient living at home or in a foster home, he or she may refer a Registered Nurse under contract with SPD to conduct a nursing assessment and may authorize follow-up visits. If appropriate, the RN develops a registered nurse plan of care for the participant and provider to follow, may delegate nursing tasks to the provider, and establish a monitoring schedule. Nursing delegation consists of training and observing that the provider is able to perform the task. The registered nurse must continue to monitor the performance of these delegated tasks and such monitoring must conform to Oregon Board of Nursing Standards. The goals of community nursing care are to: maintain participants at functional level of wellness; minimize risk for participant; maximize the strengths of the participant and the care provider; and promote autonomy and self-management of health care through teaching and monitoring. For recipients living in community-based care facilities, the case manager will work with the facility staff and the facility nurse to address health concerns.

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

Back-Up Care Providers. SPD has alternate service providers such as Medicaid contracted in-home care agencies in some regions that an individual can employ on short notice if they cannot locate a Homecare Worker who meets their needs. There are also other community-based services such as adult foster care, adult day services, residential care and assisted living for an individual who needs immediate care services if the individual is unable to identify a Homecare Worker to employ. Currently local SPD or AAA offices have referral lists of Homecare Workers enrolled in their specific regional service delivery areas.

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

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.

Local SPD or AAA case managers assist individuals to obtain and select qualified providers of in-home services by providing referral lists of Homecare Workers who have met minimum qualifications for provider enrollment, including a criminal history clearance

as described in Appendix C. Some areas of the state also have contracted in-home care agencies, adult day services and specialized living services from which the participant can select their services.

Case managers provide individuals/legal representatives interested in adult foster care, assisted living, residential care or nursing facility care with referral lists of contracted providers in the local area so that the individual/legal representative can tour the facility to see if it meets their needs and preferences. Case managers facilitate the referral of the individual and the payment authorization for facility services. Many AAA offices have their own websites providing consumer information about qualified providers in their area. SPD supports the Network of Care website which allows access to a large database of community services, resources and programs throughout Oregon.

SPD also publishes consumer guides to assist individuals in making good decisions about selecting qualified providers. These guides include The Oregon Consumer Guide for Assisted Living and Residential Care Facilities and the Client-Employed Provider Program – Employers' Guide. These guides are available on the SPD website and can also be obtained through local SPD and AAA offices.

SPD or AAA offices that license foster homes provide public disclosure files. Individuals or family members can review the public disclosure files for complaint history of a particular facility and the outcome of any investigations conducted in response to such complaints.

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):

Local SPD or AAA Case managers authorize and monitor the services reflected in the plan of care. The SPD Office of Licensing and Quality of Care Performance Evaluation Team visits local offices to sample assessments and service planning practices to ensure that plans are developed and approved according to SPD standards.

SPD has quality assurance and quality improvement activities to monitor and review the eligibility process for timeliness, accuracy, appropriateness of services, compliance with State and Federal regulation, program outcomes, consumer satisfaction, and cost effectiveness. The Performance Evaluation Unit in the SPD Office of Licensing and Quality Control has a two-year scheduled process for electronic, on-site and participant interviews for 57 local offices. The Performance Evaluation Unit does a formal finding in a report to the local office with policy and rule errors to be corrected within 30 days. The plan of correction is submitted to SPD for a final report and the results are entered into the Quality Assurance database for tracking.

The Performance Evaluation Team sends each local SPD and AAA office a 1% random individual sample survey for local offices to complete on financial and services eligibility, individual preferences, risk monitoring, individual goals, contingency plans, signed plan of care, and individual choice forms. Local office management is responsible for reviewing each case, documenting corrective actions and signing off on the review. The survey report is returned to SPD Central Office for review and database entry for tracking.

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
X	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)*:

X	Medicaid agency
☐	Operating agency
☐	Case manager
☐	Other (*specify):*

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.

Local SPD and AAA case managers are responsible for the monitoring and implementation of the service plan and to that extent the participant's health and welfare. The monitoring and follow-up depends on a participant's needs and living situation. Individuals receiving in-home services generally require more monitoring than those living in a facility.

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

b. Monitoring Safeguards. *Select one:*

X	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*:

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)*:

X	**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.
X	**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 In-Home 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 Homecare Workers. Participants establish work schedules and train employees in how they prefer to receive their services.

(b) Process for accessing participant-directed services. The local SPD or AAA Case manager will discuss various waiver services options with every eligible individual/legal representative who chooses home and community-based services. When 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 Homecare Worker (live-in, hourly, or spousal pay) or an in-home care agency.

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

1) Information and assistance in support of participant direction:

- Local SPD or AAA Case manager provides referral lists of Homecare Workers who have met minimum qualifications for enrollment including a criminal history check

conducted by DHS.

- A contract RN if referred by the local SPD or AAA Case manager may also provide care assistance training and teaching opportunities to both the participant-employer and the Homecare Worker employee. Under Oregon law, contract RNs are also able to delegate certain nursing tasks to the Homecare Worker employee such as insulin injections.
- SPD publishes a "Client-Employed Provider Program - Employer's Guide" which is provided to participants to assist them in carrying out the responsibilities of being the employer of the Homecare Worker.
- The participant-employer may also request further assistance of the local SPD or AAA Case manager in working with Homecare Worker employees.
- Most local SPD or AAA offices have developed an orientation for home care workers. SPD has prepared and distributed a Providers' Guide for the CEP program. The guide explains the program, roles of the Department, and responsibilities of the provider. Each provider in the program also signs a provider enrollment form which further describes conditions of payment.

2) Financial management services:

- SPD issues payment to the Homecare Worker employee and addresses tax and other employer-related financial requirements on behalf of the participant-employer. The participant-employer signs off on a monthly voucher verifying the number of hours their employee worked, up to the maximum monthly hours authorized by the SPD.
- SPD provides a task list based on the service plan, or AAA Case manager.

The SPD or AAA case manager 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. Staff 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 worker at any time, for any reason. SPD and AAA case managers may alter the services authorized based on reassessments of the participant's needs. In that situation, the local SPD or AAA office sends a notice of reduction or termination of services to the participant. The local office also sends a notice to the worker if the hours change.

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

X	**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:*

X	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.
X	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 In-Home Services when they apply for SPD services. SPD publishes an "Employers Guide" to the assist the participant in carrying out employer responsibilities. This guide is typically provided by the local SPD or AAA local office when an individual qualifies for waiver services and chooses in-home services. Individual assistance is provided to the participant from their local SPD or AAA Case manager as requested, including the provision of a referral list of Homecare Worker employees that the employer can interview.

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.
X		The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:
	X	Waiver services may be directed by a legal representative of the participant.

	X	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:
		Participant-appointed friends or family members may supervise the completion of work provided by the homecare worker. A relative or friend who is a paid homecare worker employee may not sign off on their own voucher showing the hours worked. If the participant-employer is unable to sign the voucher showing hours worked, and there is no other participant representative who can sign the voucher, the local SPD or AAA Case manager is responsible for signing off on the hours worked before payment can be issued. All family members, neighbors and friends and other persons involved in the participant's life are assessed as natural supports before any payment can be authorized. Payment can only be made for needs unmet by natural supports. Individuals who needs are entirely met through natural supports are ineligible for services paid through DHS. All allegations of financial exploitation of seniors and adults with physical disabilities are investigated by Adult Protective Services Workers. Any enrolled Homecare Workers who receive a substantiated adult protective services complaint (including members of the participant's support system) are terminated from providing paid services to DHS participants.

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
In-Home Services	X	☐
Non-Medical Service Transportation	X	☐

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:*

X	**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:*	
	X	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. *Select one*:

○	FMS are covered as the waiver service entitled	
	as specified in Appendix C-3.	

X	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:
		SPD performs these services on behalf of the participant when the participant chooses In-Home Services: • SPD withholds the Homecare Worker employee portion of FICA, and pays the employer portion of FICA, FUTA and SUTA; • SPD withholds income tax from the Homecare Worker employee's service payment in accordance with the Home Care Commission's (Oregon's public homecare authority) collective bargaining agreement with SEIU Local 503, OPEU, the Homecare Workers' Union. • SPD withholds union dues and the workers' compensation fee (benefit fund assessment). • Local SPD or AAA offices facilitate completion of the INS I-9 form and the W-4 form for income tax withholding when a Homecare Worker enrolls, along with other necessary application paperwork needed for provider enrollment. Local offices also enter the tax withholding information into the payment system and forward voluntary direct deposit (electronic funds deposit) requests to SPD Central Office for enrollment. • Local SPD or AAA collect vouchers signed by Homecare Worker employee and participant verifying the hours worked up to the authorized maximum and initiates payment for services as well as the next month's vouchers.
	ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
		SPD performs activities, paid through Medicaid Administration
	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:
		X — Assist participant in verifying support worker citizenship status
		X — Collect and process timesheets of support workers
		X — Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
		X — Other *(specify):*
		Workers compensation insurance is provided. SPD and AAA offices assist Homecare Workers to make voluntary direct deposit arrangements.
		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 the FMS activities of local offices through information available in provider enrollment and payment systems. SPD follows up on inconsistencies and errors. Certain edits are implemented in the payment system to prevent errors in hourly rates, hours authorized and monthly service payments to Homecare Workers. These errors can only be overridden by contacting SPD Provider Payments Unit that reviews the errors before payment is authorized.	

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)*:

X	**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:*
	Local SPD or AAA case managers assist the participant with referrals of Homecare Workers for the participants or representative to interview. Case managers orient participant-employers to the responsibilities of the program and provide them with the SPD publication "The CEP Employers Guide" which explains the program. Case managers monitor the service plan to ensure that services are being provided. After the participant-employer signs off on the voucher for payment of hours to the Homecare Worker, the Case manager reviews the voucher to ensure that both the employer and employee have confirmed the hours worked, especially if the voucher information is incomplete or to problem-solve if more hours than authorized are claimed.
☐	**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:*

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*:
X	**No.** Arrangements have not been made for independent advocacy.

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 choose to no longer direct their own services through the In-Home Services program have other service alternatives including receiving in-home services through a contracted in-home care agency, adult foster care, assisted living, residential care or nursing facility care. The individual would contact their case manager to discuss the other service options and when to implement an alternate care setting. The Case manager can contact care facilities to inquire about vacancies and make referrals to arrange alternate services. The Case manager would authorize the alternate setting in a manner that services to the individual would be uninterrupted.

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.

If an participant suffered an injury or accident leading to hospitalization or nursing facility care and the participant's physician refused to release the individual to his or her home due to safety or health concerns, the local SPD or AAA office would offer other services (either in community-based or nursing facility care) that could meet the service needs of the participant.

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	14,719	
Year 2	14,663	
Year 3	14,542	
Year 4 (renewal only)	14,513	
Year 5 (renewal only)	14,543	

*Hourly, live-in, and spousal pay In-Home Service providers

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:*
X	**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*:

X	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
X	Select staff from worker registry
X	Hire staff (common law employer)
X	Verify staff qualifications
☐	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
☐	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.
X	Determine staff duties consistent with the service specifications in Appendix C-3.
☐	Determine staff wages and benefits subject to applicable State limits
X	Schedule staff
X	Orient and instruct staff in duties
X	Supervise staff
X	Evaluate staff performance
X	Verify time worked by staff and approve time sheets
X	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)

X	Other *(specify)*:
	Identify staff and refer to DHS for provider enrollment

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.

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.

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:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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

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

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

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

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

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

SPD Central Office, Field Services, maintains an automated database that tracks each phase of the process and the outcomes(s) for each individual/legal representative who requests an administrative hearing.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

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

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

Appendix F-3: State Grievance/Complaint System

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

X	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

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

Anyone may file a grievance/complaint with the Governor's Advocacy Office in the Office of the Director of the Department of Human Services. The local SPD and AAA offices also have the responsibility to resolve any complaints that are brought to them. If the local office is unable to satisfactorily resolve the complaint, they may refer the person to the Governor's Advocacy Office.

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

a. There is no limitation on the types of complaints an individual may file. Most of the complaints break into loss of benefits or dissatisfaction with the case manager.
b. The Governor's Advocacy Office (GAO) logs the complaints into their tracking system AND
c. The GAO contacts either SPD central office staff or the local SPD or AAA offices to research and help resolve the complaint. SPD is able to get monthly reports on the types of complaints filed, the outcomes and who the complaint involves. SPD tracks those complaints and has recently begun to do a follow-up survey to assure the complaint was addressed satisfactorily.

Process and Timelines
If the participant uses the Client Complaint or Report of Discrimination Form (DHS 0170), the process is as follows:

1. The local office or the Governor's Advocacy Office (GAO) receives the completed complaint form.
If the local office receives, they must initiate the resolution process.
If the GAO receives it, the complaint is entered into the data base, then forwarded to the appropriate branch office or responsible program entity to initiate the resolution process.
If it is a report of discrimination, it is screened for either DHS central office investigation or forwarded to USDA Food and Nutrition Services (FNS) Regional Office Civil Rights Investigation if it is food stamp program-related. (FNS conducts investigations independent of DHS.)

2. Within five business days of receiving this complaint form, the participant must

be contacted by the local program supervisor.

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

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

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

6. Fact finding is conducted before participant contact, during the meeting session and following the meeting. A determination must be based on evidence. This may include interviews with internal and external parties, review of documentation and program policies, analyzing data and evidence gathered, determination of whether or not complaint is substantiated and consideration of the participant's willingness to resolve the complaint.

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

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

9. If the complaint cannot be resolved at the local office and service area levels, a Central Office team will assume reexamination and continuance of complaint process. The participant may pursue the grievance through the Governor's Advocacy Office or the appropriate federal program authority, including the court system.

10. Informal or verbal complaints are expected to be handled and resolved at the lowest level of intervention. If this is resolved locally, the GAP does not need to be notified. If not, the participant may pursue the grievance through the Governor's Advocacy Office, a higher DHS authority, or the appropriate federal program authority.

11. The GAO has two separate data systems---one specific to the Client Complaint

or Report of Discrimination Form (DHS 0710) and a second system for direct and informal contacts with the GAO via 8-800 and TTY phones, fax, letter, and e-mail. Contact information, evidence and resolution are recorded electronically and accessible for program reporting, identification of trends, system or operational issues, training needs, region/office/employee specific patterns and best practices.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical incidents that must be reported. SPD requires report of critical incidents for any individual age 65 and older and adults with disabilities when circumstances involve observed or suspected abuse defined in Oregon Administrative Rule (OAR) 411-020-0000 through 0130. Abuse in these rules means actions or inactions including abandonment, financial exploitation, neglect, physical abuse, emotional or verbal abuse, self-neglect and sexual abuse. SPD requires reporting of an additional group of critical incidents defined as abuse for these individuals who also live in community-based care facilities. These additional abuse definitions are found in (OAR) 411-050-0400 (2) for Foster Care Homes, OAR 411-055-0000 for Residential Care Facilities, and OAR 411-056-0005 for Assisted Living Facilities and include involuntary seclusion of a resident for convenience of staff or for discipline, corporal punishment, and inappropriate use of restraints.

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

DHS delegates adult protective services to Seniors and People with Disabilities (SPD). SPD assigns adult protective services responsibilities to local SPD and AAA offices, including taking reports of abuse (critical incidents) and providing the subsequent follow-up through screening, assessment, investigation, and provision of appropriate resources for victim safety. The SPD Office of Licensing and Quality of Care oversees Adult Protective Services (APS) and is the appropriate authority at state level for management of critical incidents.

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

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

The Governor's Advocacy Office (GAO) is another means by which critical incidents may come to SPD attention. This office is at DHS in the Director's Office and provides a central point of access for anyone have a problem with, or seeking information about, the entire range of DHS services. If the GAO receives a complaint involving SPD services, GAO staff refer the complaint to SPD Office of Licensing and Quality of Care where adult protective services begin if abuse is involved.

Individuals required to report critical incidents and events.

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

For Residential Care Facilities and Assisted Care Facilities, the administration of the facility is responsible for reporting abuse. All employees who have reasonable cause to believe a resident has suffered abuse are responsible for reporting to appropriate facility personnel or to the Department. This responsibility is stated in OAR 411-055-0151 (3) (4) for Residential facilities and OAR 411-056-0010 (5) for Assisted Living Facilities. If SPD discovers through licensing survey, Case manager onsite care monitoring, or complaint that a report has not been forwarded, SPD will investigate that circumstance as a rule violation.

ORS 124.060 mandates certain groups of persons to report elder abuse. Abuse mandated to be reported is defined under ORS 124.050 to be physical injury, neglect of care, abandonment, willful infliction of harm, sexual abuse, and financial abuse. ORS 124.050 (4) lists and defines the mandatory reporters to include:

- Physician, naturopathic physician, osteopathic physician, chiropractor or podiatric physician and surgeon, including any intern or resident.
- Licensed practical nurse, registered nurse, nurse's aide, home health aide or employee of an in-home health service.
- Employee of the Department of Human Services, county health department or community mental health and developmental disabilities program.
- Peace officer.
- Member of the clergy.
- Licensed clinical social worker.
- Physical, speech or occupational therapists.
- Senior center employee.
- Information and referral or outreach worker.
- Licensed professional counselor or licensed marriage and family therapist.
- Any public official who comes in contact with elderly persons in the performance of the official's official duties.
- Firefighter or emergency medical technician.

Case managers and Foster Care Home Licensors are mandatory reporters for elderly persons, age 65 or older of critical events or incidents as defined in ORS 124.050.

Timeline for Reporting. SPD expects reports as soon as abuse, neglect or exploitation is observed or suspected. There are no time limits for reporting.

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

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

SPD Licensing and Quality of Care staff train local SPD and AAA APS specialists in abuse and neglect and reporting through four mandatory training modules offered four times a year that include **Fundamentals of APS**, **APS Community Reports**, **APS Facility Reports** and **Legal Processes**. SPD APS also offers **Fundamentals** training four times a year to service case managers to provide basic training on the definitions of abuse and guidelines for determining when to refer to APS. In-Home Services providers (Homecare Workers) are trained on abuse and neglect in their Homecare Worker Orientation conducted by the local SPD and AAA offices. Homecare Workers are given a workers' guide that provides guidance on identifying indicators of abuse and reporting to the local office.

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

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

DHS advertises a central helpline 1-800-232-3020 for reporting abuse and neglect and rule violations. SPD Office of Licensing and Quality of Care staffs this line for abuse and complaint calls involving seniors and people with physical disabilities. SPD also offers translation and alternative formats for reporting.

In licensed facilities, education about protection from abuse is provided though the Residents' Bill of Rights. Sections of the Bill of Rights address the right to be safe and secure and free from abuse and neglect and improper restraint. The Residents' Bill of Rights must be posted for in a prominent place. Each resident or resident's designated representative is given a copy of the Bill of Rights. Implementation of a Residents' Bill of Rights is mandated under ORS 443.739 for Foster Care Homes; OAR 4181-055-0200 for Residential Care Facilities; and OAR 411-056-0010 for Assisted Living Facilities.

OAR 411-050-0455 (1) requires SPD to furnish each adult foster home with a Complaint Notice. This notice must be posted in a conspicuous place. It states the procedure for making complaints and has telephone numbers for making complaints to SPD and the Ombudsman.

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

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

OAR 411-020-0000 to 411-020-0130, General Adult Protective Services, details the procedures for receiving reports, investigating, and documenting critical events or incidents. In addition to General Adult Protective Services, there are also specific administrative rules for Community Based Care that govern investigations of reports of critical incidents: Foster Care Homes OAR 411-050-0455 (3)-(7); Residential Care Facilities OAR 411-055-0230; Assisted Living Facilities OAR 411-056-0230; and In-Home Services ORS 124.050 to 124.095 mandates the procedures investigations of reportedly abused older adults. In all cases, the response to critical incidents consists of a standard series of APS activities including screening, triage (response times), intervention, on-site assessment, investigation, and documentation.

- **Screening:** Local SPD and AAA offices must have screeners who receive and review reports about critical events or incidents. All reports that involve the possibility of abuse are screened for protective services. Methods of reviewing involve interviewing and assessing information to determine:
    - If the complaint is a critical event or incident that makes the state definitions of abuse (see G-1a);
    - If the reported victim is an older adult, age 65 or older, or a persons with physical disabilities;
    - Triage (response timeline). The response time is 911 for emergencies, immediately for imminent danger, and next working day for other reports of abuse.

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

- **Intervention:** If protective services are needed, then the APS specialist and case manager must immediately provide protective services to reduce or remove the harm or threat of harm. The participant has the right to refuse protective services.

  If the investigator believes a crime has been committed, local law enforcement is contacted. If the investigator believes that Medicaid fraud has occurred, a referral is made to Oregon Department of Justice, Medicaid Fraud unit. If the reported perpetrator is licensed and the investigator believes there is a licensing concern or substantiated abuse, then a report is made to the licensing agency.

- **On-site assessment and investigation:** An APS specialist conducts an evidence-based investigation including on-site assessment of the reported victim, witness interviews, and gathering evidence such as facility, medical, and financial records. The waiver participant has the right to decline participation in the investigation. SPD contracts with a PhD forensic nurse to evaluate injuries in complex cases. APS specialists will work with multi-disciplinary teams that include law enforcement or other law enforcement contacts to staff complex, difficult, and unclear incidents that have the potential of going to prosecution. The evidence is analyzed in a finding of fact. Based upon preponderance of the evidence from the finding of fact, a conclusion is determined if wrongdoing is substantiated, not substantiated, or inconclusive.

- **Documentation:** A report is written for each investigation including APS specialist observations, a review of documents and records, a summary of all witness statements, a finding of fact, and a conclusion.

  The APS specialist has 60 days from the report of the incident to complete the investigation and write the investigation report.

Distribution of investigation report for facility investigations. For Foster Care Homes, Residential Care and Assisted Living Facilities, within the next 60 days of receiving a completed investigation report the SPD Office of Licensing and Quality of Care must examine the investigation report and make a determination if there was abuse or rule violation and appropriate corrective actions. Upon determination of the findings, a public copy of the investigation must be sent to the complainant, waiver participant or their designee, and other parties. A public copy does not have the names of or any identifying information about the waiver participant, complainants, and all witnesses. The complainant and waiver participant has seven days to add information to the report.

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

Training for receiving reports and follow-up for investigation. The SPD Office of Licensing and Quality of Care provides a two-day training to APS screeners on how to screen reports of critical incidents. The training is offered 3-4 times a year.

Adult Protective Service Program Coordinators of the SPD Central Office APS Unit

conduct a series of trainings that APS specialists must complete. If required, SPD can access a DHS-maintained computerized record to confirm these trainings have been completed by APS specialists.

- **"Fundamentals of Adult Protective Services"** covers the basic information on policy and procedures and the practice of APS. The first day is open to case managers.
- Facility Adult Protective Services goes into depth on conducting facility investigations with emphasis on investigative skill development and the corrective action process.
- Community Protective Services goes into depth on conducting investigation in private homes (In-home Services participants) and assessment of capacity with emphasis on investigative, assessment, and intervention skill development
- Legal and Court Procedures is an advanced course for testifying in court when critical incidents are referred for prosecution and advocating for participants with the legal and court system.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

SPD Office of Licensing and Quality of Care develops operations and policy for APS and manages the statewide critical incident management and critical incident data systems. SPD Office of Licensing and Quality of Care oversees compliance with state and federal laws and SPD policy and procedures for both the local offices and providers. To maintain quality and assure standardization through the state, SPD trains the APS specialists, provides information technology, and conducts reviews of investigations, and gathers and analyzes APS and corrective actions data.

Facility Oversight and corrective actions: Within 60 days of a report of abuse involving a licensed facility, local SPD and AAA offices send a completed investigation report to the SPD Office of Licensing and Quality of Care to be individually reviewed. The SPD Office of Licensing and Quality of Care makes final determination of abuse, neglect, or rule violation and determines appropriateness of corrective actions or sanctions in accordance with the Administrative Rules. Actions could range from a warning letter, conditions put on the license, civil penalties, or revocation of the license.

A public copy of the investigation report is sent to the complaint, waiver participant or their designees, and other parties for review and they have seven days to add information.

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

Local SPD and AAA foster home licensors are contacted with investigation results and follow-up may include re-inspection or development of an additional corrective action plan. There are specific administrative rules for Community Based Care that govern oversight of reports about and correction actions for critical incidents: Foster Care Homes OAR 411-050-0455 (8)-(12); Residential Care Facilities OAR 411-055-025; and Assisted Living

Facilities OAR 411-056-0090.

In-home Services oversight of critical incident reports. For In-Home Services, the managers in the local SPD or AAA offices supervise reporting of and response to critical incidents. If there is a complaint or question about the investigation report, then the SPD Office of Licensing and Quality of Care reviews the complaint about the report. The local office is then asked to resolve the complaint or question in compliance to law and policy.

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

System-wide operation of data systems. SPD provides and mandates that the local office use a standardized secure incident reporting forms for documenting investigations. The reports are filed electronically into Oregon Access 723C (community APS reports) and web-based 723 (facilities).

The local offices narrate documentation and also fill out fields in the 723 incident report system, for each investigation. The data from the fields in the reports go into an SPD central database. In addition, the SPD Office of Licensing and Quality of Care assigns incident categories for tracking purposes based on review of investigation records and corrective actions. The information gathered from these forms and encoding include types of incidents, participant characteristics, gender and age of participant, providers/facilities, conclusions, outcomes to waiver participants, and corrective actions. Also captured are time-lines on when the report was made, when responded to, completion of investigation and documentation, when public copies were sent to participant and other parties, and completion of correction actions.

The data is compiled and analyzed in the central data base and data reports generated that are made available to the state office through a desktop application. Reports can be generated by many factors, including by individual, individual characteristics, providers, local office, category of critical incident, results of investigation, timeliness of investigation report completion, etc. The data reports are updated on a daily basis. Internally, SPD uses the data reports to evaluate if investigation, oversight and data systems involved in incident management assure the health and safety of service recipients. Reports are used by operations and policy analysts in SPD Central Office to review quality of response to critical incidents at all levels, gauge quality of care by providers, and guide policy to prevent reoccurrence. Examples of how reports are used to provide protections for participants and quality control:

- Corrective actions in the state office can examine the history of corrective actions taken in response to critical incidents for any licensed facility to see if there is pattern that needs attention.
- Quarterly, facility reports are sent to local office and state managers about timeliness of completion of investigation reports.
- The State office can examine reports of open and closed cases for In-home services investigations. Hard copies of reports of open and closed cases are made

to the SPD director and the State APS manager several times a year.
- Quarterly, reports are sent to local offices about investigation findings and conclusions, including corrective actions affecting participants in facilities.
- State APS Operations and Policy Analysts refer to the data reports on a regular basis to identify trends, changes in served populations, and means to improve system ability to prevent and respond to abuse, e.g. increase staff education and training, provider training, improve information system technology.

SPD prepares yearly reports of critical incidents in Oregon involving adults age 65 and older and adults with disabilities by, at minimum, living situation, participant characteristics, abuse reporter, relationship of perpetrator to victim, type of abuse or critical incident. SPD Office of Licensing and Quality of Care staff analyze this data by region, facility type, type of abuse to identify trends and patterns for follow-up with provider training, corrective action or policy revision. The Office of Licensing and Quality of Care also compares the SPD data with that of the Long-Term Care Ombudsman complaint reports as means of validating and further analyzing trends.

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

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed.

a. Applicability. *Select one:*

C	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions *(do not complete the remaining items)*	
X	This Appendix applies. Check each that applies:	
	X	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
	X	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete items G-2-c.*

b. Safeguards Concerning Use of Restraints or Seclusion

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

The use of chemical (drugs), physical (mechanical) or personal restraints in community-based services is subject to restrictions in administrative rules for those facilities. Involuntary seclusion for convenience of staff or discipline is prohibited and will be investigated as abuse according to all facility rules.

Assisted Living Facilities (ALFs) and Residential Care Facilities (RCFs).
Physical restraints are not permitted except when a resident's actions present an imminent danger to self or others and only when immediate action is taken by medical, emergency or police personnel. Supportive devices with restraining qualities are permitted under the following documented circumstances: the resident requests or approves and the facility has informed the individual of the risks and benefits associated with the device; the facility nurse, a physical therapist or occupational therapist has conducted a thorough assessment; the facility has documented unsuccessful use of less restrictive alternative; and the facility has instructed caregivers on the correct use and precautions related to the use of the device. Documentation of the use of supportive devices with restraining qualities must be included in the resident service plan and evaluated on a quarterly basis. (OAR 411-055-0220 for RCFs and 411-056-0005 and 0010 for ALFs)

Psychoactive medications cannot be used to treat a resident's behavioral symptoms without a consultation from a physician, nurse practitioner, registered nurse or mental health professional. Facility administered psychoactive medication(s) are used only when required to treat a resident's medical symptoms or to maximize a resident's

functioning. Prior to administering any psychoactive medications to treat a resident's behavior all caregivers administering medications for the resident must know the specific reasons for the use of the medication for that resident, the common side effects and when to contact a health professional regarding side effects. "As Needed" medications that are given to treat a resident's behavior will have written, specific parameters. These medications may be used only after documented, non-pharmacological interventions have been tried with ineffective results. All caregivers must have knowledge of non-pharmacological interventions. (OAR 411-055-0210 for RCFs and 411-056-0015 for ALFs)

Non-Relative Adult Foster Home. Physical restraints may be used only after: physician, nurse practitioner, nurse, mental health clinician, physical or occupational therapist assessment; documentation of unsuccessful use of all other alternatives; and only when required to treat a resident's medical symptoms or to maximize a resident's physical functioning. The assessment must be placed in the resident's chart and include guidance for the correct use of the restraint, alternative less restrictive measures which may be used in place of the restraint whenever possible, and the dangers and precautions related to the use of the restraint. The least restrictive restraint must be used and must allow for quick release. A written signed order from the physician or nurse practitioner must be obtained and the orders must specify the parameters including type, circumstances, and duration of use. The frequency for reassessment of the physical restraint use must be determined by the prescriber based on recommendations made in the initial assessment. Physical restraints may only be used with the resident's/legal representative's consent. Physical restraints may not be used for the discipline of a resident or for the convenience of the foster home provider. Residents restrained during waking hours must be released at least every two hours for a minimum of 10 minutes and be repositioned, offered toileting, exercised or provided range of motion. Physical restraint use at night (including side rails) is discouraged limited to unusual circumstances. The frequency of night monitoring for resident safety and need for assistance shall be determined in the assessment. No tie restraints may be used to keep a resident in bed. Physical restraint use must be recorded in the care plan showing why and when the restraint is to be used, along with instructions for periodic release. Any less restrictive alternative measures planned during the assessment and cautions for maintaining safety while restrained must also be recorded in the care plan.(OAR 411-050-0447)

A provider must not request a psychoactive medication to treat a resident's behavioral symptoms without a consultation from the physician, nurse practitioner, registered nurse or mental health professional. The consultation must include a discussion of alternative measures to medication use including behavioral interventions. These medications may be used only after documenting all other alternative considerations and only when required to treat a resident's medical symptoms or to maximize a resident's physical functioning. Psychoactive medications must never be given to discipline a resident or for the convenience of the adult foster home. Psychoactive medications may be used only pursuant to a prescription that specifies the circumstances, dosage and duration of use. The provider and all caregivers must know the specific reasons for the use of the psychoactive medication for an individual resident, the common side effects and when to contact the physician, nurse practitioner, or mental health professional regarding those side effects. All caregivers

must also know the behavioral interventions to be used along with the medication. The frequency of the reassessment of the psychoactive medication use must be determined by the individual completing the initial assessment.

The Bill of Rights for all licensed facilities informs residents of right to be free of physical and chemical restraints and the right to complain about any violation of this and other rights. The Bill or Rights explains who to contact if you feel any of these rights are being violated. SPD is informed of complaints received by the Governor's Advocacy Office and the Ombudsman's Office about unauthorized use of restraints.

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

Agency responsible for overseeing use of restraints: SPD is responsible for overseeing the use of restraints, including establishing and communicating policy through administrative rules and policy transmittals.

How Oversight is Performed:

- **RCFs and ALFs**: A full list of facility residents is prepared by the facility prior to a survey by the Client Care Monitoring Unit (CCMU) of SPD's Office of Licensing and Quality of Care (CCMU). CCMU then selects a 10% sample from this list. If CCMU detects a trend involving use of restraints as it reviews cases on the sample list, another 10% sample will be drawn from a list of cases that involve restraints or restrictive devices. The use of those restraints is reviewed against rules for that facility's licensure.
- **Non-Relative Foster Home and Relative Foster Home**: Local SPD and AAA offices are responsible for licensure and monitoring of all Foster Homes on a yearly basis. The licensors make periodic visits to facilities and report any observed or suspected misuse of restraints to local APS specialists. Case managers are also informed if needed to authorize a contract registered nurse to assess the need for restraints. If the local SPD or AAA licensors has a foster home with repeat rules violations, potential for harm or actual harm, the local office reports the foster home provider to SPD Licensing and Quality of Care Corrective Action Unit. In addition, SPD and AAA case managers are responsible for monitoring the plan of care in all facilities to ensure the services provided adequately meet the individual's care needs. If they observe any misuse of restraints, they report it to APS. Case managers and contract registered nurses are mandatory reporters of abuse.

c. Safeguards Concerning the Use of Restrictive Interventions

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

RCF's and ALF's: Supportive devices with restraining qualities (e.g. geri chairs, recliners, tray chairs) may be utilized for residents who are unable to evaluate the

risks and benefits of the device when all the requirements in G.2.b.i pertaining to restraints have been met. Documentation of the use of supportive devices with restraining qualities must be included in the resident service plans and evaluated on a quarterly basis.

Non-Relative and Relative Foster Homes: These devices are considered physical restraints in foster care administrative rules and subject to the same limits and safeguards.

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

SPD oversees use of restrictive interventions through the licensing review process. Every two years the Client Care Monitoring Unit (CCMU) of SPD's Office of Licensing and Quality of Care (CCMU) reviews RCFs and ALFs. A 10% resident sample is selected and if a trend is seen involving restrictive devices the full 10% sample will be drawn from those cases involving restraints or restrictive devices. The use of those restraints or restrictive devices are then are reviewed against the rules for that facility's license. Local SPD or AAA offices are responsible for licensing and monitoring Non-Relative and Relative Adult Foster Homes annually.

Appendix G-3: Medication Management and Administration

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

a. Applicability. Select one:

X	**Yes**. This Appendix applies *(complete the remaining items)*.
O	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

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

Entity with ongoing responsibility for monitoring participant medication regimens. The Client Care Monitoring Unit (CCMU) of the SPD Office of Licensing and Quality of Care is responsible for monitoring the administration of medications in Residential Care Facilities (RCF) and Assisted Living Facilities (ALF). Local SPD or AAA offices are responsible for onsite licensing and monitoring Non-Relative and Relative Adult Foster Homes.

Methods for conducting monitoring.

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

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

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

Non-Relative Foster Homes. Licensed annually by local SPD or AAA office licensors. Licensors may also visit the facility more frequently, especially if they are following up on corrective action plans or have received complaints about care or referrals from Adult Protective Services.

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

Methods used to ensure participant medications are managed appropriately:

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

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

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

Non-Relative and Relative Foster Homes: SPD/AAA office's adult foster home licensors review safety and storage of medications, accuracy of dispensing, and monitor for medication errors.

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

c. Medication Administration by Waiver Providers

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

X	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the*

	remaining items)
○	Not applicable (*do not complete the remaining items*)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

RCFs and ALFs: Facilities must have a safe medication system in place that is approved by a pharmacist consultant, registered nurse or physician. There must be professional oversight of the medication system. Staff administering medications must have the appropriate training, education or experience to be able to demonstrate ability to perform the task. Written signed physician (or other legally recognized practitioner) orders shall be documented in the resident's record. The resident or personal legally authorized to make health care decisions for the resident has the right to consent to, or refuse medications. The physician must be notified if a resident refuses consent to an order. An accurate medication record must be kept of all medications, including over-the-counter medications, administered by the facility. Residents may keep over-the-counter medication in their unit without a written order unless medically contraindicated. Residents must have a physician's (or other legally recognized practitioner) order of approval for self-administering of prescription medications. They may also keep their own prescription medications in their unit. (OAR 411-055-0210 and 411-056-0015)

Non-Relative and Relative Adult Foster Homes: Providers and caregivers must demonstrate an understanding of each resident's medication regime. The provider and any resident care managers must pass the basic adult foster home classes using curriculum developed by SPD Central Office and provided by local SPD or AAA office licensors that include coursework in medication administration. The provider must obtain a written order for any medications and place it in the resident's record. Orders must be carried out as prescribed unless the resident or the resident's legal representative refuses to consent. Changes may not be made without an order and the prescriber must be notified if a resident refuses to consent to an order. Over-the-counter medication or home remedies requested by the resident must be reviewed by the resident's physician/nurse practitioner or pharmacist as part of developing the care plan. Residents must have a physician/nurse practitioner written order of approval to self-medicate. Persons able to handle their own medication regime may keep them in their own room. (OAR 411-050-0447)

iii. Medication Error Reporting. *Select one of the following:*

○	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
X	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:
	Medication errors that result in harm to the resident are considered abuse and must be reported to APS as abuse. RCFs, ALFs and Non-Relative Adult Foster Homes are required to record wrong dose, wrong person, wrong medication, or missed medications. Medication errors that do not result in harm and therefore are not reported will be evaluated at the time license survey.

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

Entity with ongoing responsibility for monitoring the performance of waiver providers in the administration of medications: The Client Care Monitoring Unit of SPD is responsible for monitoring administration of medications in Residential Care Facilities (RCF) and Assisted Living Facilities (ALF). Local SPD and AAA offices are responsible for onsite licensing and monitoring for Non-Relative Foster Homes.

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

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

Frequency of monitoring:
RCF and ALF: Onsite licensing reviews are conducted every 24 months. If systemic issues were identified as part of an abuse allegation or investigation follow up by APS, CCMU would do an early full survey of the facility.

Non-Relative Adult Foster Homes: Licensed annually by the local SPD and AAA licensors. Licensors may also visit the facility more frequently, especially if they are following up on corrective action plans or have received complaints about care or referrals from Adult Protective Services.

Appendix H: Quality Management Strategy

Attachment #1 to Appendix H

The Department of Human Services, Seniors and People with Disabilities (SPD), administers waiver services for three populations: seniors, adults with physical disabilities and individuals of any age with developmental disabilities. Figure H.0 summarizes currently-approved waivers and associated services.

Figure H.0 SPD Waiver Services in Combined HCBS Quality Management Strategy

Reference	Control #	Type	Ages	Undup. # 2004-05	Services	Methods
APD	0185.90.R2 for seniors, adults w/physical disabilities	Regular, NF	18 +	28,222	Described in Appendix C	Traditional and participant-directed
DDC	#0117.90.R3 for individuals with developmental disabilities (Comprehensive)	Regular, ICF/MR	All	5,597	24-hour residential, in-home, crisis diversion, extended state plan, day habilitation, supported employment, respite, non-med. transportation, spec. medical equipt/supplies, family training, environmental accessibility adaptations	Traditional and participant-directed
DDS	#0375 Support services for adults with developmental disabilities	Regular, ICF/MR	18 +	3,266	Homemaker, respite, supported employment, environ. access. adaptations, non-med. transportation, spec. medical equip./supplies, chore services, personal emergency response systems, family training, extended state plan services, special diets, support services brokerage, emergent services, community inclusion, community living, specialized supports	Participant-directed
CIIS	#40193 Medically fragile children (MFC)	Model, hospital	0-17	84	Homemaker, respite, environmental accessibility adaptations, non-medical transportation, family training, spec. medical equipment and supplies, chore services, extended state plan services	Participant (family)-directed
	#40194 Children with severe behavioral challenges (DDB)	Model, ICF/MR		108		

Quality assurance activities and processes related to the waivers were primarily developed prior to 2001-03 when services for the two populations were administered by separate Department of Human Services program units. Although a single management team now ultimately acts on system performance information, much of our current quality management strategy still reflects these dual processes. SPD has directed staff and technical resources since 2003 toward stabilizing QA functions associated with each waiver and making progress toward consolidation where possible by: establishing common goals and outcomes for four separate waiver service QA plans; taking initial steps to bring activities and processes in each current waiver service QA plan under a single combined plan to coordinate reporting and trend analysis related to common goals and outcomes; and taking advantage of opportunities such as our Real Choice QA/QI grant and MMIS improvements to build processes that address quality across waivers. The quality management strategy overview in Figure H.1 reflects one more step toward consolidation.

SPD depends on system "tiers" to perform activities related to quality: providers; local points of entry and case management services; consumers and advocates; and DHS/SPD program management and administration staff. Roles and responsibilities in quality management processes, including establishing priorities and developing strategies for remediation and improvement, are indicated in Figure H.2.

Figure H.1: SPD Multi-Waiver Quality Management Strategy Overview

H.1.a: Level of Care Determination. 1) An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future. 2) LOC of enrolled participants is reevaluated at least annually or as specified in approved waiver. 3) Processes and instruments described in approved waiver are applied to determine LOC. 4) State monitors LOC decisions and takes action to address inappropriate LOC determinations.

Major Features of Program Design		Methods for Discovering if Program Works as Designed (Includes Frequency)	Source/Type Information to Measure System Performance	Entities Who Review and Act On Data	Plan for improving QM Tools, Processes
APD	Initial, annual, as-needed LOC determination conducted and recorded using CA/PS instrument and processes; SPD case manager training; Monthly "review due" reports generated by SPD to local offices; SPD advance notice re re-assessment	SPD Performance Evaluation Team (PET) 2-year cycle of random sample of individual cases in each local SPD and AAA office—through record reviews and on-site interviews Local SPD and AAA office review of 1% sample of individuals in services. Quarterly through 2005, resuming regular schedule with new web-based system implementation 9/06. Data submitted to SPD.	SPD Performance Evaluation Team (PET) reports---at least annual by state and office, e.g. LOC current; ongoing monitoring by case manager; consistency and accuracy of local processes, LOC determinations. Local Office Review annual report, aggregate data by state and office, e.g. LOC current; ongoing monitoring and update by case manager	Local SPD and AAA offices SPD APD QA Committee QAC) Performance Evaluation Team (PET) ; SPD mgt team	Revise tools, implement web-based reporting for Local Office Reviews and consolidate database for PET and Local Office Reviews 9/06.
DD (DDC, DDS, CIIS)	Initial, annual, as-needed LOC determination made and recorded using Title XIX Waiver Form (all); SPD case manager training (all); Initial score, as-needed review using CIIS entry criteria(CIIS); Local QA program required (all)	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, brokerages. Data submitted to SPD for central database and reporting.	HCBS Waiver Review Report: Statewide, county, brokerage aggregate data, e.g.: TXIX Waiver Form in place; timely and current LOC; LOC reviewed at least annually; documentation present supporting eligibility and LOC	Community DD Programs (CDDPs); Support Service Brokerages (Brokerages) SPD DD QA Committee (QAC); SPD mgt team	

H.1.b: Service Plans. 1) Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means. 2) State monitors service plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in service plan development. 3) Service plans are updated/revised at least annually or when warranted by changes in waiver participant needs. 4) Services are delivered in accordance with the service plan, including in the type, scope, amount, duration and frequency specified in the service plan. 5) Participants are afforded choice between waiver services and institutional care. 6) Participants are afforded choice between/among waiver services and providers.

	Major Features of Program Design	Methods for Discovering if Program Works as Designed (Includes Frequency)	Source/Type Information to Measure System Performance	Entities Who Review and Act On Data	Plan for improving QM Tools, Processes
APD	CA/PS initial assessment, plan and annual review; SPD case manager training; Case manager monitoring; Offer, document choice; Improvement Project: QA/QI grant re assessing individual risk in self-directed services	SPD Performance Evaluation Team (PET) 2-year cycle of random sample of individual cases in each local SPD and AAA office—record review, on-site interviews; Local SPD/ AAA office review --1% sample of individuals in services. Quarterly through 2005, resume schedule 9/06. Data submitted to SPD for analysis, reports; Improvement Projects: QA/QI grant re assessing satisfaction in self-directed services; SPD survey every 2 years	SPD Performance Evaluation Team (PET) reports---at least annual by state and office, e.g.: assessment indicate preferences discussions re needs, plans; plan complete, all needs addressed; ongoing monitoring is occurring; client goals entered/ addressed; SPD 914 (Client Choice) for current care setting; individual satisfaction Local Office Review annual report, aggregate data by state and office with same or similar datapoints as PET report.	Local SPD and AAA offices APD QAC PET; SPD mgt team	PET and Local Office Review improvements noted in H.1.a; satisfaction survey for in-home services field-tested—statewide implementation Fall 2006; survey for rest of system in development by through APD QA Committee, anticipated field test by 1/07, first report completed by 11/07; QA/QI grant product re risk field test 5-6/06, implement Fall 2006
DD (DDC, DDS, CIIS)	Person-centered planning (all); Standard ISP process for 24-Hour residential settings (group homes), inc. protocols for health, risk, behavior, etc. (DDC); Monitoring by case managers (DDC, CIIS), personal agents (DDS); Offer choice, document (all); Improvement Projects: QA/QI grant re assessing individual risk in self-directed services (DDS, DDC); System Transformation Grant (DDC)	Employment Outcomes System (EOS): web-based data --individual wage, hour, integration collected every six months; Case manager service monitoring -- on-site visits to 24-hour res., FH monthly or quarterly; Annual Staley Team Field Review of services for 5% of individuals in support services, including provider files associated with services; Annual HCBS Waiver Review for 5% of individuals in waiver services-- by SPD Central Office and CDDP QAstaff-- all waivers, counties, brokerages. Data to SPD for central database and reporting; Satisfaction surveys-annual brokerage surveys; Improvement Projects: QA/QI grant re assessing satisfaction in self-directed services; SPD survey every 2 years;	EOS Report: Aggregate wage, hour, integration data across state, county, region, provider; Staley Team Report: State, brokerage data, e.g.: ISP consistent w/ LOC, other assessments; ISP identifies preferences, needs, abilities, health status, other available supports; provider job descriptions, service agreements reflect needs, preferences; individuals receive services; personal agents respond to requests, needs; free choice among support service options, providers; choices, options discussed; HCBS Waiver Review Report: Statewide, county, brokerage aggregate data, e.g.: FH and 24-hour res. monitored by case manager; services received consistent with ISP; choice offered/documented; notice of fair hearing rights Brokerage Statewide Satisfaction Report: state, brokerage summary Third-party review of strengths and issues over first years of ISP implementation—one-time report.	CDDPs; Brokerages DD QAC; Staley Implementa-tion Group (SIG) SPD mgt team	DD QAC work group proposing improvements in EOS---implement changes by 4/07; working w/ University of Oregon on method for statewide evaluation of case manager service monitoring with report by 6/07; QA/QI grant satisfaction survey and risk assessment product development and implementation on same schedule as APD above; satisfaction survey for rest of system in development by through DD QA Committee, anticipated field test by 1/07, first report completed by 11/07; work group currently ISP process based on third-party review report; System Transformation Grant activities to increase ability for participants to purchase chosen services through individual budgets

H.1.c. Qualified Providers. 1) The state verifies that providers meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services. 2) The State verifies, on a periodic basis, that providers continue to meet required license and/or certification standards and/or adhere to other State standards. 3) The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. 4) The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.

Major Features of Program Design		Methods for Discovering if Program Works as Designed (Includes Frequency)	Source/Type Information to Measure System Performance	Entities Who Review and Act On Data	Plan for improving QM Tools, Processes
APD	Provider standards in administrative rule and contract; Criminal record review processes; Participant direction; Foster provider training; Contract RN for foster homes and in-home services; SPD training for FH licensors and contract RN's; Payment suspension w/o current license or criminal history clearance	Licensing reviews every 2 years for RCF and ALF, every year for foster homes SPD Performance Evaluation Team (PET) 2-year cycle of random sample of individual cases in each local SPD and AAA office—record review, on-site interviews Adult Protective Services –SPD Client Care Monitoring Unit (CCMU) review of activity and outcomes Periodic review of provider sanctions Improvement Projects: QA/QI grant re assessing satisfaction in self-directed services; SPD survey every 2 years	Licensing summary reports ---by provider, type of provider, results, type of citation SPD Performance Evaluation Team (PET) reports---at least annual by state and office re complaints, satisfaction	Local SPD and AAA offices APD QAC PET; SPD mgt team	Satisfaction survey (QA/QI grant and overall) status and milestones noted in H.1.b; Workgroup to re-evaluate standards for Home-Delivered Meals by 6/07
DD (DDC, DDS, CIIS)	Provider standards in administrative rules (all); Criminal record review processes (all); Participant direction, confirmation of necessary skills (DDS, DDC); Brokerage and CDDP confirmation of provider qualifications (inc. non-licensed, non-certified) (DDS, DDC); Direct care core competencies (DDC)	Licensing or Certification Reviews—from 1 to 3 years, depending on type of program Annual Staley Team Field Review of services for 5% of individuals in support services, including provider files associated with services OIT reports –statewide data by county, type, outcome, victim, perpetrator, provider, etc. Office of Investigation and Training (OIT) review of protective services investigations SERT review of provider sanctions---every 2 months Improvement Projects: QA/QI grant re assessing satisfaction in self-directed services; SPD survey every 2 years; CDDP review of comprehensive in-home service provider qualifications	Licensing and certification summary reports---by provider, type of provider, results, type of citation Staley Team Report: Statewide and brokerage aggregate data re documentation of provider qualifications prior to service OIT reports –statewide data by county, type, outcome, victim, perpetrator, provider, etc. SERT review report---by provider, location, reason, status, outcome	CDDPs; Brokerages DD QAC; SIG SPD mgt team	Satisfaction survey (QA/QI grant and overall) status and milestones noted in H.1.b; complete review of provider qualifications in 100% of in-home comprehensive services by 12/06.

H.1.d Health and Welfare.

Assurance Requirement	Major Features of Program Design		Methods for Discovering if Program Works as Designed (Includes Frequency)	Source/Type Information to Measure System Performance	Entities Who Review and Act On Data	Plan for improving QM Tools, Processes
There is a continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate.	APD	Administrative rules address health and safety in service provision; Personal safety planning in plan of care; Case management monitoring; Governor's Advocacy Office grievance and complaints; Improvement Project: QA/QI grant re assessing individual risk in self-directed services	Licensing reviews every two years for RCF and ALF, every year for foster homes SPD Performance Evaluation Team (PET) 2-year cycle of random sample of individual cases in each local SPD and AAA office—record review, on-site interviews Local SPD/ AAA office review --1% sample of individuals in services. Quarterly through 2005, resume schedule 9/06. Data submitted to SPD for analysis, reports Improvement Projects: QA/QI grant re assessing satisfaction in self-directed services; SPD survey every 2 years	Licensing reports ---by provider, type of provider, results; SPD Performance Evaluation Team (PET) annual, as requested report by state and office, e.g.: risks of service refusal discussed, documented; plans for emergencies; Local Office Review annual report, aggregate data by state and office with same or similar datapoints as PET report.	Local SPD and AAA offices APD QAC PET; SPD mgt team	PET and Local Office Review improvements noted in H.1.a; QA/QI grant product re risk status and milestones noted in H.1.b.; satisfaction survey (QA/QI grant and overall) status and milestones noted in H.1.b
	DD (DDC, DDS, CIIS)	Administrative rules address health and safety in service provision; Serious Event Review Team (SERT) state and local processes for web-based reporting and review of serious events; Service monitoring by local case managers (DDC), personal agents (DDS), and CIIS service coordinators Governor's Advocacy Office grievance and complaints; Improvement Project: QA/QI grant re assessing individual risk in self-directed services	Annual HCBS Waiver Review of services for 5% of individuals in waiver services conducted by SPD Central Office and CDDP Quality Assurance staff---all waivers, counties, brokerages. Data to SPD for central database and reporting. Improvement Projects: QA/QI grant re assessing satisfaction in self-directed services; SPD survey every 2 years	HCBS Waiver Review Report: Statewide, county, brokerage aggregate data re grievance receipt and resolution of	CDDPs; Brokerages DD QAC SPD mgt team	

Assurance Requirement	Major Features of Program Design		Methods for Discovering if Program Works as Designed (Includes Frequency)	Source/Type Information to Measure System Performance	Entities Who Review and Act On Data	Plan for improving QM Tools, Processes
On an ongoing basis the State identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation	APD	State and local processes for reporting, investigating, other follow-up re abuse, neglect, exploitation; SPD training for local APS workers; Governor's Advocacy Office grievance and complaints; On-site licensing reviews; Case manager service monitoring Improvement Project: QA/QI grant re assessing individual risk in self-directed services	Adult Protective Services –SPD Client Care Monitoring Unit (CCMU) review of activity and outcomes SPD Performance Evaluation Team (PET) 2-year cycle of random sample of individual cases in each local SPD and AAA office—record review, on-site interviews Local SPD/ AAA office review --1% sample of individuals in services. Quarterly through 2005, resume schedule 9/06. Data submitted to SPD for analysis, reports Improvement Projects: QA/QI grant re assessing satisfaction in self-directed services; SPD survey every 2 years	Adult Protective Services at least annual reports by type, outcome, living setting, action, victim age, action, etc. SPD Performance Evaluation Team (PET) annual, as requested report by state and office for personal safety and risk identification Local Office Review annual report, aggregate data by state and office with same or similar datapoints as PET report.	Local SPD and AAA offices APD QAC PET; SPD mgt team	PET and Local Office Review improvements noted in H.1.a; QA/QI grant product re risk status and milestones noted in H.1.b.; satisfaction survey (QA/QI grant and overall) status and milestones noted in H.1.b
	DD (DDC, DDS, CIIS)	State and local processes for reporting, investigating, other follow-up re abuse; Serious Event Review Team (SERT) state and local processes for web-based reporting and review of serious events Improvement Project: QA/QI grant re assessing individual risk in self-directed services	Office of Investigation and Training (OIT) review of protective services investigations Local SERT monthly review, analysis of serious events State SERT reviews every two months of OIT, SERT, Licensing data DD QA Committee reviews at least annually Improvement Projects: QA/QI grant re assessing satisfaction in self-directed services; SPD survey every 2 years	OIT reports –statewide data by county, type, outcome, victim, perpetrator, provider, etc. SERT reports—statewide, individual, county, brokerage data, e.g. timely report of abuse allegation; timely completion of investigation and follow-up	CDDPs; Brokerages DD QAC SPD mgt team	Provide training and technical assistance through University of Oregon to improve local review of serious events---4 regional sessions 7-10/06.

H.1.e. Administrative Authority. The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Major Features of Program Design		Methods for Discovering if Program Works as Designed (Includes Frequency)	Source/Type Information to Measure System Performance	Entities Who Review and Act On Data	Plan for improving QM Tools, Processes
APD	Transfer AAA contracts for performance of waiver functions; Case manager informs individuals of right to fair hearing;	SPD Performance Evaluation Team (PET) 2-year cycle of random sample of individual cases in each local SPD and AAA office—record review, on-site interviews Local SPD/ AAA office review --1% sample of individuals in services. Quarterly through 2005, resume schedule 9/06. Data submitted to SPD for analysis, reports Periodic management review of contested cases	SPD Performance Evaluation Team (PET) report---at least annual, by state and office, e.g. SPD 914 (Client Choice) form signed for current care setting; SPD 539R (Rights and Responsibility) signed Local Office Review annual report, aggregate data by state and office with same or similar datapoints as PET report.	Local SPD and AAA offices APD QAC PET; SPD mgt team	PET and Local Office Review improvements noted in H.1.a
DD (DDC, DDS, CIIS)	Case manager responsibilities around TXIX Waiver Form, informing individuals of right to fair hearing; CDDP QA programs required by administrative rule	Contested case review 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, brokerages. Data from individual file reviews submitted to SPD for central database and reporting. Local QA program (CDDP) report required by contract, including distribution of resources and status of QA program.	HCBS Waiver Review Report: Statewide, county, brokerage aggregate data, e.g.: TXIX Waiver Form in place; timely and current LOC; LOC reviewed at least annually; documentation present supporting eligibility and LOC; information re right to fair hearing. Local QA Program summary report every 2 years of use of QA resources and presence of program elements required by rule. Annual Staley Progress Report, including information re contested case hearings	CDDPs; Brokerages DD QAC; SIG SPD mgt team	Provide training and technical assistance through University of Oregon to improve local QA programs—2x/yr for all QA coordinators and special TA for 7 CDDPs through June 2007.

H.1.f State Financial Accountability. Claims for federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the service plan, and properly billed by qualified waiver provider in accordance with the approved waiver.

Major Features of Program Design		Methods for Discovering if Program Works as Designed (Includes Frequency)	Source/Type Information to Measure System Performance	Entities Who Review and Act On Data	Plan for improving QM Tools, Processes
APD	Service prior-authorization and payment authorization processes; MMIS and SFMA; Central Office program specialist contract and claim reviews; Rate exception committee; Program Improvement: MMIS expansion and improvement	DHS Audit Unit, Secretary of State, other internal or external periodic audit activities. SPD Research, Planning and Rate Setting Unit monthly review of waiver services and caseload counts	DHS Audit Unit or SOS Audit Division reports Management reports, e.g. HCBS Capacity Report w/Medicaid bed occupancy from enrollment data, licensed community facility Medicaid rate distribution, etc.	SPD mgt team	MMIS expansion and improvements to be completed by June 2009
DD (DDC, DDS, CIIS)	Contract and payment processes (all); CPMS (all); eXPRS (DDC); Base Plus criteria scoring and review (DDS); Program Improvement: System Transformation Grant (DDC)	DHS Audit Unit, Secretary of State, other internal or external periodic audit activities. Annual Staley Team Field Review of services for 5% of individuals in support services, including provider files associated with services. Direct Care Staffing monthly online survey of wages, FTE, turnover	DHS Audit Unit or SOS Audit Division reports Staley Team Report: Statewide, brokerage aggregate data, e.g.: accuracy of individual benefit level; process for review and approval of rate exceptions; evidence of monitoring of exceptions for continued cost effectiveness. Direct care Staffing summary reports Management Reports, e.g. service expenditures, vacancy rates, etc.	CDDPs Brokerages Staley Implementation Group DD QAC SPD mgt team	MMIS expansion and improvements to be completed by June 2009; System Transformation Grant to allow individual budgeting for 5000 participants by 2010; DD QAC subgroup assigned to recommend direct care staffing survey report and process improvements by 11/06.

Figure H.2: APD Waiver Service Quality Management Roles and Responsibilities

Quality Management Tiers	Activity	Information Produced to Support Quality Management	Ongoing Roles in SPD Quality Management
Service Providers	Delivery of care and support Direct observation of individual	Individual records; payment claims; critical incident reports; policies and procedures; employee qualification and training records; medication and restraint administration records (facilities)	Provide services required in plan of care. Maintain practice and setting consistent with administrative rules. Identify and inform case manager of changing needs, problems, solutions. Obtain and maintain proof of provider and staff qualifications. Provide ongoing training to meet individual needs.
Local SPD and AAA Offices	LOC determination, re-determinations; assist with waiver enrollment; prior authorize services; payment authorization; service planning, coordination, monitoring; foster home licensing; information re choice, rights, options in waiver services; receive and respond to critical incident reports; provider recruitment, information about waiver requirements; verification of provider qualifications; planning re personal safety and disaster response; conducting Local Office 1% reviews; participant information re waiver services	Case files with eligibility and LOC determinations/re-determinations, plans of care, case notes, records of choice and information about rights, documents supporting eligibility. Complaint logs. Reports of protective services and investigation. License review records. Re-affirmation of homecare worker continuing qualification based on criminal history review. Service authorization, reauthorization, termination records.	Timely and accurate LOC determinations, re-determinations. Timely development and review of plan of care that meets individual needs, based on individual goals and preferences. Confirm services provided. Timely entries to payment system to maintain accuracy of individual enrollment, provider enrollment, prior authorization, claims processing. Timely response to, investigation of, critical incidents. Timely completion of foster care licensing. Timely resolution of complaints and appropriate referral for fair hearing. Review and modification of practices, if necessary, based on Local Office Review and Performance Evaluation Team reports.
Consumers and Advocates	Participation in advisory groups (e.g: state APD QA Committee, QA/QI grant stakeholder group re consumer survey, personal safety planning; local councils; People w/Disabilities Advisory Council; Governor's Commission on Senior Services, MLTQRAC). Satisfaction surveys. Employ/direct Homecare Workers.	Survey findings. Recommendations for QA/QI project products. APD QA Committee minutes. Draft report on Future of Long Term Care and records of community forums. Confirmation of receipt of Homecare Worker services.	Overall: Information about services through complaints, satisfaction surveys, employer actions. APD QAC: quarterly meetings to recommend priorities, assist with analyzing system performance reports, assist with defining outcomes, advise re improving performance evaluation instruments and reports. QA/QI grant stakeholder group: monthly meetings to define indicators of health and safety for in-home service recipients, evaluate system features, design and test instruments to assessment health, safety, satisfaction
SPD Program Management and Administration	Establish standards for services; ALF, RCF licensing reviews; receive and respond to critical incident reports; manage critical incident system; fair hearing processes; coordination w/GAO, Ombudsman, local offices re complaints and grievances; obtain stakeholder involvement; performance measurement and improvement; priority setting; manage claims and payment processes; provider contracting and enrollment	Rules, policy transmittals, action requests, information memoranda. Standard information and training, e.g.: APS brochures and local APS training; case manager training, foster provider self-study. Individual protective services investigation reports. Case management reports (e.g. LOC re-assessments due, caseload). Waiver service QA plan. Evidentiary reports, e.g.	PET: Gather, analyze, report data re system performance; revise processes based on data; recommend SPD Management Team and Local SPD/AAA Office actions based on data SPD Management Team: Define goals and objectives; evaluate and respond to information about quality; design and implement strategies to remediate problems and improve services, systems, technology; report to Legislature every two years on SPD performance re Oregon Progress Board

Quality Management Tiers	Activity	Information Produced to Support Quality Management	Ongoing Roles in SPD Quality Management
		Performance Evaluation Team (PET) reports; APS summary reports; summary report of complaints; progress toward Oregon Progress Board high level performance measures; Local Office Review summaries and reports; financial reports; enrollment reports.	

What types of quality information will SPD compile over the course of the waiver period? How often and to whom will it be reported? The types of quality information SPD produces and will produce during the period the waiver is in effect are indicated in Figure H.1 under the column heading Source/Type Information to Support Performance and target audiences are indicated in the same chart under the column heading Entities Who Review and Act on Data. Some of these reports are posted on websites or otherwise shared for broader review, e.g.: Serious Event Review Team (SERT) meeting notes and reports are posted for review by SPD, CDDP, and Office of Investigation and Training staff who also have access to the secure SERT site; Staley annual progress reports are provided to the Staley Implementation Group, an group composed of consumers, advocates, providers, and representatives from CDDPs and Brokerages to advise SPD on development of self-directed support services for adults; DD HCBS Waiver Review reports are posted on the SPD QA in HCBS website (http://www.oregon.gov/DHS/spd/qa/home.shtml); some participant and caseload data are posted at http://www.oregon.gov/DHS/spd/data/#spwpd. SPD staff prepare regular and *ad hoc* reports on a variety of topics (e.g. protective services, PET findings, Local SPD/AAA Office review findings, licensing citation summaries) for APD or DD Quality Assurance Committee review, both of which include consumer, advocate, provider, and local DD, SPD, or AAA office representation.

SPD waiver quality management activities take place with the context of Oregon's focus on achieving quality-of-life goals in the state's 20-year strategic vision, *Oregon Shines.* Every year the Oregon Progress Board issues its Oregon Benchmark Report, available at http://egov.oregon.gov/DAS/OPB/ . This report includes performance information toward high level outcomes for SPD: 1) the percentage of individuals with developmental disabilities who live in community settings of five or fewer; 2) the percentage of Oregon's eligible seniors and people with disabilities who are living outside of institutions; 3) the percentage of Seniors and People with Disabilities consumers with a goal of employment who are employed; and 4) the percentage of seniors and adults with disabilities who are re-abuse within 12 months of first substantiated abuse.

How will SPD periodically evaluate and revise, as appropriate, the Quality Management Strategy? The discussion of reports and target audiences highlights a persistent challenge associated with consolidating quality management across complex and well-established systems: affecting a change in one area may divert resources from, or have unintended consequences in, another area. SPD has focused considerable energy in the last two years on establishing a common basic structure through which quality information can be distilled across all waivers, i.e. similar advisory groups and processes, similar QA plans and formats, similar goals and objectives, similar expectations about reporting and analysis, similar information system needs. For most of that time, information system capacities could not meet advisory group and management demand. It has been a challenge to keep other elements of the quality management structure moving forward. Now that we see several positive information system developments on the near horizon, nearly every other element of that structure needs refining and retuning. The SPD Management Team, with the assistance of its Quality Assurance Committees, will undertake these improvements in the first 18 months of the waiver.

Figure H.3: Ongoing Improvements to Waiver Quality Management Strategy*

Task	Milestones
Improve quality assurance advisory process	Design and implement strategy for obtaining broader, more consistent consumer and advocate participation by February 2007
Evaluate and redesign (where required) outcomes and indicators under combined waiver quality assurance plan	Progressively review, revise, adopt through reports, presentations, discussions at quarterly quality assurance committee meetings—complete by July 2007
Coordinate waiver quality reporting through parallel processes on common outcomes for all waivers.	Develop and implement content and format protocol for combined waiver reporting by December 2007
Improve dissemination of system performance information, especially to providers and participants	Develop a schedule of reporting by type of report, target audience, distribution venue. Implement by April 2008 with method for obtaining further input on content, accessibility, usefulness

(*Tasks and milestones related to participant satisfaction survey implementation, self-directed service personal safety and emergency planning, PET and Local Office Review process and database improvements, and MMIS expansion and improvements are indicated in Figure H.1 above.)

Making these improvements will require evaluating SPD's current approach in each area and may result in changes in the overall quality management strategy. Such changes will be communicated through the annual CMS-373Q. In addition, SPD will ask its quality advisory groups to assist with designing and implementing a formal, more comprehensive evaluation of the overall quality management strategy after improvements in Figure H.3 have been completed and prior to October 1, 2009.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

SPD requires providers to maintain relevant service record information for a minimum of three years, per federal regulatory requirements. Local AAA's and service providers are required to permit authorized representatives of DHS to review these records for audit purposes. Audit staff from the Department of Human Services and the Secretary of State's Office periodically review payment records based on their applicable state statutes and administrative rules to ensure provider billing integrity. Staff from both agencies set audit priorities each year based upon assessed risk analysis. Audit methods include on-site review as well as independent data analysis.

To maintain a clear audit trail, SPD makes payments directly to nearly all waiver service providers through the CMS-approved Oregon Medicaid Management Information System (MMIS). While regional transportation brokers, entities that provide Non-Medical Service Transportation under direct contract with DHS, are exceptions to MMIS payment, they are required by contract to permit State and Federal review of records to conduct audits or investigate unresolved questions of fact.

DHS Audits:

Providers. DHS auditors evaluate provider financial condition and contractual compliance, review fiscal audits performed on contractors by other agencies, provide consultation to the Secretary of State's Division of Audits programs, and evaluate provider financial system issues for compliance with federal and state standards. Audits occur on a periodic basis. DHS usually determines the frequency of an audit. A government body, an organization or an individual can trigger an audit. DHS auditors perform both desk reviews and on-site examinations of providers' records, facilities and operations, and other information

Internal Programs. DHS auditors provide timely, accurate, independent and objective information about DHS operations and programs. An internal audit committee made up of representatives from each DHS administrative unit, including SPD, works closely with the Audit Unit to ensure comprehensive audit coverage. The committee approves an annual audit plan of risk-based and required cyclical audits, then meets every two months, updating the plan as needed based on special requests, investigations, legislative inquiry, or other administrative direction.

Auditors have complete access to all necessary activities, records, property and employees. The auditors have no direct authority over activities being reviewed. They abide by the

Institute of Internal Auditors' Code of Ethics and practices conform to the Standards for the Professional Practice of Internal Auditing, as promulgated by the Institute of Internal Auditors, the American Institute of CPA's (AICPA), the Federal General Accounting Office (GAO) Yellow Book, Institute of Internal Auditors (IIA), and Information Systems Audit and Control Association (ISACA).

DHS internal audits fall into two categories: classification and issue-specific. Priority for audits is set by:

- Risk analysis, assessing the extent of fiscal, legal, and/or public policy impact for each potential audit subject, with those having the highest level of risk given top priority; and
- Database analysis, which determines the quantity, magnitude, degree of aberration, and inconsistencies that exist in current application of practices.

Audit Unit staff and the audit committee use the audit process to assess functions and control systems and to make recommendations to DHS administration regarding issues such as: economical and efficient use of resources; progress meeting DHS goals and outcomes; reliability and integrity of information; consumer health and safety; compliance with laws, regulations, policies, procedures, and contact terms; safeguarding assets, adequacy of internal controls; sound fiscal practices; effective management systems; and security and controls of information systems.

Secretary of State Audits:

The Audits Division is responsible for carrying out the duties of the Secretary of State's Office as the constitutional Auditor of Public Accounts. The Audits Division is the only independent auditing organization in the state with the authority to review programs of agencies in all three branches of state government and other organizations receiving state money. Authority for the responsibilities of the Audits Division is found in sections 297.00 through 297.990 of the Oregon Revised Statutes. Secretary of State auditors review the areas of finance, performance, information technology, and fraud and abuse. Most recently, the agency conducted a review of SPD Medicaid in-home care payments (see www.sos.state.or.us/audits/index.html).

Frequency of SOS audits is based on risk assessment and on standards established by nationally-recognized entities including, but not limited to, the GAO and the National Association of State Auditors. Types of audits include:

- Financial and compliance audits of all components of state government and state-aided institutions. These audits determine whether a state agency has conducted its financial operations properly and has presented its financial statements in accordance with generally accepted accounting principles;
- Examinations of internal control structures and determination whether state agencies have complied with finance-related legal requirements. At the end of each engagement, the Division prepares an opinion regarding financial statements, reports significant finds, and recommends any necessary improvements;
- Financial and compliance audits of the state's annual financial statements. This audit, the largest audit of public funds in the state and a major engagement of the Division, complies with the Single Audit Act of 1984 (PL 92-502) which requires such an audit annually as a condition of eligibility for Federal funds;
- Performance audits of the operations and results of state programs to determine whether the programs are conducted in an economical and efficient manner;
- Special studies and investigations regarding misuse of state resources or inefficient

management practices;

- Requested audits or special studies for counties. In accordance with statutory provisions and in cooperation with the State Board of Accountancy and the Oregon Society of Certified Public Accountants, the Division: develops the standards for conducting audits of all Oregon municipal corporations; prescribes, revises, and maintains minimum standards for audit reports; and reviews reports, certificates, and procedures for audits and reviews of corporations. The Division evaluates reports of audits or reviews of these municipal corporations and auditor's work papers for compliance with the standards.

In addition to audit activities of the DHS Audit Unit and Secretary of State Audit Division:

- The SPD Research, Planning and Rate Setting Unit regularly reviews random records of waiver provider payments for accuracy and consistency with agency policy and conducts monthly reviews of Waiver services expenditures and caseload counts. These monthly reviews involve the review of expenditures in each of the care settings to ensure that payments are unduplicated and within the rate schedule. The report also details expenditures by living situation and a recipient count. SPD pulls the data using DSSURS (Decision Support Surveillance and Utilization Review System) and reviews all cleansed, paid claims on a monthly basis. The DSSURS derives data directly from the MMIS.

- The DHS Office of Payment Accuracy and Recovery receives reports of fraud in DHS programs and investigates allegations. The Office maintains a hotline for anyone to report fraud and will investigate allegations against providers such as billing for services not rendered, intentionally billing in duplicate, billing for higher level of services than was delivered, billing for services provided by unlicensed or otherwise ineligible practitioners, and kickback schemes.

APPENDIX I-2: Rates, Billing and Claims

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

SPD determines rates using a variety of methods depending on the type of waiver service:

- **In-Home Services.** The participant's CA/PS assessment determines the amount and scope of services for the individual. The assessment suggests an amount of paid hours within each ADL and IADL category. The local SPD or AAA case manager then authorizes hours up to the maximum allowed by administrative rule. If the individual needs full assistance with their ADL's, a higher rate is paid than if the individual needs partial assistance. IADL hours are all paid at the same rate. Reimbursement rates for Home Care Workers that provide In-Home services are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at 2-year intervals. The collective bargaining process is a public process. Economic analysis of the workforce, economic conditions and population are utilized as markers for setting the rate during the bargaining process. A comparative analysis is done to determine if the proposed rate is consistent with employment in the health care field.

- **Residential Care, Non-Relative Adult Foster Home, Relative Foster Home, Assisted Living Facilities.** Reimbursement rates for Community-Based Care (CBC) facilities are established by maintaining a rate schedule. The Research, Planning and Rate Setting unit within SPD is responsible for establishing the rate schedule for all waiver services. The rate schedule identifies the waiver service and reimbursement rate for that service. Reimbursement rates are uniform throughout the state based on the type of community-based care facility providing the services. Rates for community-based care facilities are not re-set regularly. These rates are redetermined periodically. The reimbursement rate is paid based on the individual's assessed needs. The assessment determines the amount and scope of services for the individual. For community-based care, the basic rate is the default rate. Depending on the need, the individual may qualify for one of three add-on payments. The add-ons are for specific ADL, Behavioral or Complex Medical needs. Add-ons are automatically added to the rate if certain conditions are met based on the assessed needs. There is no process for requesting add-ons to the assessed rate.

  Adult Foster Homes and Residential Care Facilities are paid a base rate with add-ons for specific medical, behavioral and ADL needs. The reimbursement rate may include the base rate with up to three add-on payments.

  Residential Care Facilities and Adult Foster Homes may also apply for a contracted rate. Contracted rates are established for providers targeting a specific

population and negotiating a specific rate for services provided to any individual within that target population. There are three types of contracted rates: (a) Supplemented Program Contract: A supplemented program contract pays a rate in excess of the published rate schedule to providers in return for additional services delivered to target populations. (b) Consistent Revenue Contract: A consistent revenue contract allows a payment rate based on average facility casemix. The contracted rate is in the range allowed by the published rate schedule and is based on client needs. (c) Specific Needs Setting Contract: A specific needs setting contract pays a rate in excess of the published rate schedule to providers who care for a group of clients all of whose service needs exceed the service needs encompassed in the base payment and all add-ons. The provider must show the additional costs associated with providing care to the target population.

Assisted Living Facilities rates are paid based on the individual's assessed needs. The individual's needs result in a reimbursement in one of 5 payment levels. The different payment levels reflect the individual's acuity and ADL needs.

Add-ons are part of the assessed rate if certain conditions are met in the CA/PS assessment. Contracted rates are approved centrally. The provider submits a proposal for a contracted rate. A committee at SPD Central Office consisting of both program staff/management and rate staff/management review the proposal and determine if the provider meets the criteria. Contracted rates are renegotiated at contract renewal, usually at 1-2 year intervals.

- **Adult Day Service** rates are set through a contracting process utilizing cost data submitted by the provider. These rates vary by provider. The contracting process requires each provider to submit a detailed cost report showing the costs for providing services to all individuals served. The Research, Planning and Rate Setting Unit and the Home and Community Supports Unit Reimbursement Rates negotiate a reimbursement rate with the provider based on the submission of a cost report and a scope of work. The negotiated rate is determined based on the different types of services offered by the ADS provider. The programs offer a variety of services that are specific to the needs of the individual.

- **Home Delivered Meals.** Home Delivered Meal rates are established utilizing detailed cost reports. The Research, Planning and Rate Setting Unit conducts an analysis of the cost reports. A weighted average is used to determine a statewide reimbursement rate.

Opportunity for Public Comment. Rate changes for the services above, with the exception of In-Home Services that are subject to the bargaining process, are presented to the Medicaid Long-Term Care Quality and Reimbursement Advisory Council (MLTCQRAC). The Council is a public body that has a statutory mandate to review and comment on Long-Term Care reimbursement changes. The Council's findings on reimbursement changes are submitted to the legislature and to the Department for review.

Monitoring. Licensing surveys, monthly reports on caseload and costs in each CBC setting, quarterly long-term care capacity surveys broken down by county, and MLTCQRAC meetings are among the ways that monitoring is used to assure consistency, efficiency, economy and quality of care.

Other rate determination methods include:

- **Non-Medical Service Transportation**. Mileage reimbursement for Homecare Workers is negotiated per the process described above. Contract rates for transportation brokerages are individually negotiated with the provider.
- **Specialized Living Services.** Contract rates for transportation brokerages are individually negotiated with the provider.
- **Home Accessibility Adaptations**. Cost of adaptations vary.
- **Community Transition Services.** Payments are based on lowest market rate as evidenced by at least three bids.

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

Provider billings for waiver services flow directly to the State's claims payment system. Provider invoices are input directly into the claims payment system (Medicaid Management Information System or MMIS) and paid through the State Financial Management Application or SFMA once the claim has been validated.

Homecare Workers providing In-Home Services submit invoices/vouchers that show the number of hours authorized, the number of hours worked, and signatures of individual and provider to verify the hours worked. Claims are submitted to the local office that serves the Medicaid recipient. Local office staff enter these invoices/vouchers directly into a central payment system. For In-Home Services, each individual receives a monthly statement showing their client contribution amount. Individuals are required to send payment of their client contribution directly to SPD in the month of service.

CBC facilities receive a payment contract (512) that shows the services to be provided and the rate to be paid for each individual for a set time period, usually one year. The provider signs and returns the 512 to the local office as an agreement to provide services at the rate listed. These providers do not submit monthly invoices for claims. CBC facilities with contracts bill in the same manner, using 512's. Vendor claims for CBC facilities contain service rate, client contribution, room and board and personal spending allowance. The vendor claim for other services includes service rate and total service units. Client contribution, room and board and personal spending are not included.

Providers with contracts to provide services such as Adult Day Services or Home Delivered Meals submit invoices each month to verify the number of clients served and the service units. These invoices are input directly into the MMIS by SPD staff.

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

○	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):

	☐	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	☐	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
X		**No**. Public agencies do not certify expenditures for waiver services.

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

a) The claims system contains edits that ensure recipient eligibility prior to approval for payment for any type of provider claim. The Client Maintenance System contains the individual's Medicaid eligibility information. The Claims system reads the eligibility file to ensure eligibility prior to payment. If an individual is not eligible for services on the date the claim is processed, the claim is denied and no payment is made.

b) All services are prior authorized for payment based on the approved plan of care. For all waiver services, the case manager authorizes the specific services to be provided in the plan of care. Providers receive a copy of the plan of care, specifying the services to be provided prior to the provision of services. The case manager authorizes services for individual who live at home using a form that specifies the ADL and IADL tasks to be performed and the number of hours authorized for each task. This information is used to generate a voucher that shows the number of hours authorized. A task list is provided to each Homecare Worker explaining the tasks that are to be performed. The individual reviews the task list with the Homecare Worker to determine how the tasks are to be completed. Case managers authorize CBC services using the 512 system. The 512 is populated with specific tasks and the monthly reimbursement amount. This amount is effective until the client's condition changes, or the rate schedule changes. The 512 is mailed directly to the provider to advise them of the tasks and reimbursement amount. The plan and statement with reimbursement is generated by the case manager through the CA/PS assessment and/or the 512 system. The plan and statement are provided any time there is a change in the plan or reimbursement amount. The plan is mailed to the residential provider, signed by the provider and returned to the local SPD or AAA office. The interface between MMIS and the Client Maintenance System checks for eligibility prior to

payment.

c) Residential providers (Relative and Non-Relative Adult Foster Homes, Residential Care Facilities, Assisted Living Facilities, and Specialized Living Facilities receive a plan detailing the services to be provided along with a statement showing the reimbursement rate. The provider signs and returns this statement prior to the provision of services. In-home services providers must return an invoice, signed by the client to verify the provision of services prior to claims processing.

d) Home Delivered Meals are prior-authorized by local SPD or AAA case managers. Providers submit 599A invoices to local offices. Local offices review for eligibility and prior-authorized status and then submit invoices to SPD Central Office for payment directly to the provider through MMIS.

e) Non-Medical Service Transportation provided by Homecare Workers is subject to the process described above. The SPD Central Office program analyst responsible for transportation contracts reviews services invoiced against rider/participant eligibility records.

f) Home Accessibility Adaptations and Community Transition Services are prior-authorized based on participant eligibility.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

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

○	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
X	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
	Payments for Non-Medical Transportation services provided by contract are not paid through an approved MMIS. The SPD or AAA office case manager prior-authorizes services. The provider completes invoice indicating services was delivered and the case manager approves payment for the participant/rider based on the prior-authorization. Contractor submits approved payment request to SPD Central Office. A check for local match is attached to the invoice. When SPD receives the invoice, list of prior-authorized participants/riders, and match check, the program analyst reviews to assure eligibility and appropriate use of ride, then authorizes payment to contractor for total cost.
○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

X	The Medicaid agency makes payments directly to providers of waiver services.
☐	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

○	**No**. The State does not make supplemental or enhanced payments for waiver services.

X	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.
	Exceptional rate payments are made for services provided in Adult Foster Homes, Residential Care Facilities, and for recipients receiving In-Home Services. The services provided under an exceptional rate are for direct services provided to an individual. These are enhanced payments made to Adult Foster Care and Residential Care Facility providers for services, documented in the Plan of Care, that require additional levels of skill on the part of the provider, or additional staffing to meet the individual's needs. The provider's skill level relates to the provider's ability to provide services to an individual with complex medical or behavioral needs. The provider may need to hire a staff person with additional knowledge or abilities consistent with the needs of the individual specifically to provide care to that individual. Additional staffing may be the result of an individual who needs two-person transfers or an individual with unscheduled nighttime needs that precludes the primary provider from being able to sleep for more than 4 hours in a night. Individuals needing ventilator care require multiple providers that must have fairly extensive knowledge of the provision of ventilator care. The payments are requested at a rate above the scheduled rate for the individual's assessed need. Enhanced payments for In-home services recipients are made to In-Home services providers for the provision of in-home services, documented in the Plan of Care, that exceed the maximum number of hours of service under OAR 411-030-0070. All exceptional rate payments are pre-approved centrally by a committee consisting of SPD Program and Rate setting staff and management. OAR 411-027-0000 and 0050 document the services and requirements to document the need for exceptional rate payments to providers. There are no specific criteria for in-home plans exceeding the maximum hours in the Rule. The exceptions committee makes a determination, based on the individual's needs, that the placement is the most appropriate for the resident, special services are necessary to meet the individual's needs and the provider is capable of meeting those needs. In many cases, there will be a time, after a medical procedure for example, that the individual may need additional assistance, not provided by Home Health, that would require hours exceeding the maximum hours rule. The exceptions committee makes a determination of whether the proposed exceptional rate ensures that the cost and quality of care provided is justified. The committee reviews all aspects of the care plan, including appropriateness of setting, cost and ability of the provider to provide the care needed. If any of these are in question, the committee will offer support to the case manager to assist in finding a more appropriate setting, or care plan for the individual that better meets their needs and is consistent with efficiency, economy and quality of care.

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

X	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
	Some local transit districts, county governments, and council of governments contract with SPD to provide Non-Medical Service Transportation.
O	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

X	The amount paid to public providers is the same as the amount paid to private providers of the same service.
O	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
O	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

X	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
O	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
O	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

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

○	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
X	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

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

○	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
X	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

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

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

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

X	**Appropriation of State Tax Revenues to the State Medicaid agency**
☐	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

X	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
	a) County governments have authority to levy taxes and assign use of state cigarette funds for local transportation; b) Local tax dollars and state cigarette tax funds are primary resources. c) Non-Medical Service Transportation contract providers send checks for non-Federal portion per process described in I.3.a.
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☐	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
X	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

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

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

○	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
X	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

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

SPD has established by Administrative Rule that room and board costs are not included in service payments. SPD ensures these costs are excluded through from payment through these methods:

CBC other than In-Home Services: SPD annually determines the amounts providers must collect from participants for room and board. These amounts are publicized through SPD policy transmittal processes and input into the CBC provider payment system (512) as an amount that the participant is responsible for paying. The service rate is the only amount the provider can receive from SPD.

In-Home Services: Providers invoice only for hours of service and authorized rates do not include room and board by rule.

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

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

O	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
X	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

X	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

X	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care *(specify)* :			Nursing Facility				
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D′	Total: D+D′	Factor G	Factor G′	Total: G+G′	Difference (Column 7 less Column 4)
1 - 06/07	$9,985	$3,199	$13,184	$26,284	$2,051	$28,334	$15,150
2 - 07/08	$10,344	$3,337	$13,680	$27,072	$2,139	$29,211	$15,531
3 - 08/09	$10,663	$3,480	$14,144	$27,884	$2,231	$30,115	$15,972
4 - 09/10	$10,984	$3,630	$14,614	$28,721	$2,327	$31,048	$16,433
5 - 10/11	$11,352	$3,786	$15,138	$29,583	$2,427	$32,009	$16,871

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	
1 - 06/07	29,089
2 - 07/08	29,037
3 - 08/09	28,982
4 - 09/10	29,033
5 - 10/11	29,085

Appendix J-2 - Derivation of Estimates

Table J-2-a: Unduplicated Participants			
Waiver Year	Total Number Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		N/A	N/A
Year 1	29,089	N/A	N/A
Year 2	29,037	N/A	N/A
Year 3	28,982	N/A	N/A
Year 4	29,033	N/A	N/A
Year 5	29,085	N/A	N/A

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

Actual days of waivered service for the year divided by the number of unduplicated participants, based upon CMS-372(S) data..

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

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

Actual costs for waiver services provided to the average unduplicated waiver participant, projected forward. Inflation varies by underlying services, but average is just above 3%.

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

Actual acute care costs for unduplicated waiver participants, as reported on the CMS-372(S) waiver report, projected forward. Medicare Part D reduced the estimated drug cost component by 90%. Medical Inflation used: 4.3% (2005 Actual).

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

Actual per capita Nursing Facility costs of both waiver and non-waiver participants, from the MMIS report that produces other 372(S) data. Inflation: 3.0%

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

Actual per capita Acute Care costs for participants in Factor G, from the MMIS report that produces other 372(S) data. Medicare Part D reduced the estimated drug cost component by 90%. Medical Inflation used: 4.3% (2005 Actual).

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

☒	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: 1 - 06/07

Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Non-Relative Adult Foster Care	Month	2,927	9.631023	$1,147.81	$32,356,770.00
Relative Adult Foster Care	Month	1,732	9.630506	$811.82	$13,541,187.00
Residential Care	Month	2,910	9.629870	$1,291.98	$36,205,056.00
Assisted Living	Month	5,056	9.630145	$1,367.89	$66,602,580.00
Specialized Living	Month	205	9.658537	$1,350.50	$2,673,990.00
Home-Delivered Meals	Meal	1,085	316.208646	$5.36	$1,838,943.00
In-Home Services:					
- HCW Hourly (less Transp)	Hour	13,042	665.851015	$12.66	$109,939,806.35
- HCW Live-in	Hour	1,529	2584.344264	$5.21	$20,587,119.00
- Spousal Pay	Month	148	10.925676	$1,366.21	$2,209,161.00
- In-Home Agency	Hour	460	186.548104	$14.10	$1,209,951.00
Adult Day Care	Day	140	131.040000	$45.00	$825,552.00
Home Accessibility Adaptations. Est	Adaptation	90	1.0	$1,964.80	$176,832.24
Non-Medical Transportation - (From HCW Hourly)	Miles	5,828	375.208211	$0.42	$918,419.65
Non-Medical Transportation - (Contracted)	Rides	662	76.770193	$26.39	$1,341,189.09
Community Transition Services	Transition	24	1.0	$657.37	$15,776.94
GRAND TOTAL:					$290,442,333.27
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					29,089
FACTOR D (Divide grand total by number of participants)					$9,985
AVERAGE LENGTH OF STAY ON THE WAIVER					293

Waiver Year: 2 - 07/08					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Non-Relative Adult Foster Care	Month	2,894	9.637181	$1,193.56	$33,288,390.00
Relative Adult Foster Care	Month	1,631	9.637036	$840.14	$13,205,325.00
Residential Care	Month	3,004	9.640124	$1,347.76	$39,029,691.00
Assisted Living	Month	5,111	9.638636	$1,426.57	$70,277,217.00
Specialized Living	Month	205	9.658537	$1,401.75	$2,775,465.00
Home-Delivered Meals	Meal	1,080	316.065491	$5.48	$1,870,602.00
In-Home Services:					
- HCW Hourly (less Transp)	Hour	12,993	665.686253	$12.95	$112,007,936.16
- HCW Live-in	Hour	1,523	2582.081997	$5.33	$20,960,283.00
- Spousal Pay	Month	147	10.939976	$1,397.63	$2,247,639.00
- In-Home Agency	Hour	459	186.819776	$14.42	$1,236,519.00
Adult Day Care	Day	139	131.731557	$46.04	$843,024.00
Home Accessibility Adaptations. Est	Adaptation	90	1.000000	$2,041.07	$183,695.87
Non-Medical Transportation - (From HCW Hourly)	Month	5,823	375.066053	$0.43	$939,124.14
Non-Medical Transportation - (Contracted)	Month	708	71.800966	$28.87	$1,467,608.87
Community Transition Services	Transition	24	1.000000	$682.89	$16,389.32
GRAND TOTAL:					$300,348,909.36
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					29,037
FACTOR D (Divide grand total by number of participants)					$10,344
AVERAGE LENGTH OF STAY ON THE WAIVER					293

Waiver Year: 3 - 08/09					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Non-Relative Adult Foster Care	Month	2,881	9.638338	$1,241.10	$34,462,930.10
Relative Adult Foster Care	Month	1,571	9.638472	$869.68	$13,168,729.30
Residential Care	Month	3,059	9.638139	$1,400.56	$41,292,804.48
Assisted Living	Month	5,132	9.638347	$1,485.79	$73,493,113.99
Specialized Living	Month	206	9.626199	$1,454.41	$2,884,090.56
Home-Delivered Meals	Meal	1,070	314.165285	$5.61	$1,885,839.96
In-Home Services:					
- HCW Hourly (less Transp)	Hour	12,887	664.929751	$13.25	$113,538,583.57
- HCW Live-in	Hour	1,510	2580.185320	$5.45	$21,233,635.09
- Spousal Pay	Month	145	10.958962	$1,429.78	$2,271,988.04
- In-Home Agency	Hour	460	186.630066	$14.75	$1,266,285.00
Adult Day Care	Day	140	133.823663	$46.04	$862,573.80
Home Accessibility Adaptations. Est	Adaptation	93	1.000000	$2,082.89	$193,708.67
Non-Medical Transportation - (From HCW Hourly)	Month	5,826	374.982963	$0.44	$961,246.33
Non-Medical Transportation - (Contracted)	Month	709	71.692923	$29.55	$1,502,034.84
Community Transition Services	Transition	27	1.000000	$703.25	$18,987.63
GRAND TOTAL:					$309,036,551.38
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					28,982
FACTOR D (Divide grand total by number of participants)					$10,663
AVERAGE LENGTH OF STAY ON THE WAIVER					293

Waiver Year: 4 - 09/10					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Non-Relative Adult Foster Care	Month	2,883	9.639461	$1,291.09	$35,880,122.52
Relative Adult Foster Care	Month	1,536	9.638487	$902.77	$13,365,253.72
Residential Care	Month	3,099	9.638938	$1,454.21	$43,438,808.88
Assisted Living	Month	5,129	9.639303	$1,548.42	$76,553,863.17
Specialized Living	Month	207	9.637706	$1,508.98	$3,010,422.88
Home-Delivered Meals	Meal	1,069	312.082446	$5.74	$1,914,956.61
In-Home Services:					
- HCW Hourly (less Transp)	Hour	12,862	664.548355	$13.55	$115,817,553.85
- HCW Live-in	Hour	1,506	2575.320454	$5.58	$21,641,653.93
- Spousal Pay	Month	145	10.995585	$1,462.66	$2,325,577.97
- In-Home Agency	Hour	461	187.085320	$15.09	$1,301,457.16
Adult Day Care	Day	141	136.873479	$46.04	$888,533.35
Home Accessibility Adaptations. Est	Adaptation	105	1.000000	$2,124.43	$223,065.13
Non-Medical Transportation - (From HCW Hourly)	Month	5,835	375.101205	$0.45	$984,921.99
Non-Medical Transportation - (Contracted)	Month	710	71.598458	$30.28	$1,539,280.93
Community Transition Services	Transition	36	1.000000	$731.54	$26,335.28
GRAND TOTAL:					$318,911,807.37
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					29,033
FACTOR D (Divide grand total by number of participants)					$10,984
AVERAGE LENGTH OF STAY ON THE WAIVER					293

Waiver Year: 5 - 10/11					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Non-Relative Adult Foster Care	Month	2,893	9.639988	$1,345.39	$37,520,890.71
Relative Adult Foster Care	Month	1,543	9.640928	$940.20	$13,986,369.42
Residential Care	Month	3,105	9.639582	$1,506.57	$45,092,998.70
Assisted Living	Month	5,139	9.639229	$1,616.55	$80,077,419.49
Specialized Living	Month	208	9.649069	$1,566.32	$3,143,614.05
Home-Delivered Meals	Meal	1,071	310.500917	$5.87	$1,952,047.85
In-Home Services:					
- HCW Hourly (less Transp)	Hour	12,889	664.594790	$13.86	$118,724,236.78
- HCW Live-in	Hour	1,508	2572.891279	$5.71	$22,154,343.48
- Spousal Pay	Month	146	10.950424	$1,496.30	$2,392,233.83
- In-Home Agency	Hour	462	187.514929	$15.44	$1,337,596.49
Adult Day Care	Day	142	139.988926	$46.04	$915,202.80
Home Accessibility Adaptations. Est	Adaptation	117	1.000000	$2,166.82	$253,518.37
Non-Medical Transportation - (From HCW Hourly)	Month	5,835	375.386608	$0.46	$1,007,575.19
Non-Medical Transportation - (Contracted)	Month	711	71.481606	$31.20	$1,585,690.76
Community Transition Services	Transition	36	1.000000	$763.72	$27,494.03
GRAND TOTAL:					$330,171,231.97
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					29,085
FACTOR D (Divide grand total by number of participants)					$11,352
AVERAGE LENGTH OF STAY ON THE WAIVER					293