U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
Region 10

FINAL REPORT

Home and Community-Based Services Waiver Assessment
Oregon Waiver
Comprehensive Services
Control #0117
Support Services
Control #0375

January 2007 Review

Wendy Hill-Petras, Health Insurance Specialist
Lydia Skeen, Health Insurance Specialist
Gene Frogge, Health Insurance Specialist

Home and Community-Based Waiver Services
Oregon
Comprehensive Services Waiver

Introduction:

Pursuant to section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a State to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare & Medicaid Services (CMS) has been delegated the responsibility and authority to approve State HCBS waiver programs.

CMS must assess each Home and Community-Based waiver program in order to determine that State assurances are met. This assessment also serves to inform CMS in its review of the State's request to renew the waiver. CMS reviewed the following two Oregon HCBS waivers in January 2007.

Support Services Waiver (#0375)

Administrative Agency:	Oregon Department of Human Services
Operating Agency:	Seniors and People with Disabilities (SPD)
State Waiver Contact:	Deanna Hartwig
Target Population:	MR/DD individuals who do not live in a community home licensed under Oregon Administrative Rule (OAR), an adult foster home, home with 24-hour residential services, or supported living program. The cost of waiver services does not exceed $20,000 a year.
Level of Care:	ICF/MR
Number of Waiver Participants:	3,476
Effective Dates of Waiver:	July 1, 2004, through June 30, 2009

Approved Waiver Services:

Homemaker, respite, supportive employment services, diet, specialized support, support service brokerages, emergent services, community inclusion, community living, environmental adaptations, transportation, specialized medical equipment and supplies, chores, personal emergency response systems (PERS), family training, physical therapy, occupational therapy, and speech, hearing and language therapy.

Comprehensive Waiver (#0117)

Administrative Agency:	Oregon Department of Human Services
Operating Agency:	Seniors and People with Disabilities (SPD)

State Waiver Contact: Deanna Hartwig

Target Population: MR/DD individuals in out-of-home settings, or whose annual cost of home services exceeds $20,000 a year.

Level of Care: ICF/MR

Number of Waiver Participants: 5,733

Effective Dates of Waiver: July 1, 2003, through June 30, 2008

Approved Waiver Services:

Respite, habilitation (residential, day, prevocational, and supported employment services, adult and child foster care, adult and child group homes, supported living services), environmental adaptations, transportation, specialized medical equipment and supplies, family training, physical therapy, occupational therapy, speech therapy, in-home support services, and crisis diversion services.

CMS Contact: Wendy Hill-Petras
wendy.hillpetras@cms.hhs.gov
(206) 615-3814

BACKGROUND AND DESCRIPTION

The Oregon waivers under review were approved under section 1915(c) of the Social Security Act (the Act) as a statutory alternative to Medicaid-funded institutional care. The Secretary of Health and Human Services renewed these waivers with effective dates of July 1, 2004, (#0375) and July 1, 2003, (#0117). The current effective periods are July 1, 2004, through June 30, 2009, (#0375) and July 1, 2003, through June 30, 2008, (#0117). The State was granted a waiver of Section 1902(a)(10)(B) of the Social Security Act in order to provide home and community-based services to individuals who are mentally retarded or developmentally disabled who would otherwise require an ICF/MR level of care.

In January 2007, the Centers for Medicare & Medicaid Services (CMS) conducted an on-site review of two of the State's currently approved waivers, the Support Services (#0375) and Comprehensive waivers (#0117). The review was comprehensive in scope addressing the six assurances defined in the Protocol, as revised by the interim guidance procedures of 2004. The review included a pre-site review of the State's quality assurance plans and reports; freedom of choice documentation; participant plans of care and level of care decisions; and a quality assurance review of state policy and procedures. During the course of the on-site visit CMS staff conducted interviews with State Medicaid Staff; client advocacy groups; nine brokerage directors, county managers, personal agents and case managers. The team from the CMS Seattle Regional Office used the *Regional Office Protocol for Conducting Reviews of State Medicaid*

HCBS Waiver Programs, December 20, 2000, version, to conduct the review. The protocol reflects a national effort to standardize the HCBS waiver reviews, with an emphasis on quality assurance. This report follows the protocol in addressing areas assessed in the review process and indicates key findings and recommendations as appropriate. The CMS review focused on statutory requirements under section 1915(c)(2)(A) of the Act requiring states to assure that:

- Necessary safeguards have been taken to protect clients' health and welfare.
- Necessary safeguards have been taken to assure financial accountability.
- Waiver enrollees meet the appropriate level of care.
- Consumer freedom of choice is assured in selecting available care alternatives.
- Cost neutrality is maintained relative to the cost of institutional care.

The Oregon State Medicaid Agency is the *Single State Medicaid* Agency responsible for administering home and community-based services in Oregon. The CMS review documented that the State was in substantial compliance with the federal waiver requirements.

Health Insurance Specialists Lydia Skeen, Gene Frogge and Wendy Hill-Petras of the Seattle Regional Office conducted the review. This review focused on the extent to which the policies and procedures have been implemented, and the results of the State's oversight activities. The State provided evidence of how it identified quality-related issues and corrective actions taken.

The purpose of this report is to provide findings of the on-site review and recommend actions which CMS believes will strengthen the State's oversight of the waiver program. The CMS team reviewed its findings with the State staff during the exit interview conducted on January 25, 2007.

Home and Community-Based Waiver Services

Introduction:

Pursuant to section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a State to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The CMS has the responsibility and authority to approve State HCBS waiver programs.

CMS must assess each Home and Community-Based waiver program in order to determine that State assurances are met. This assessment also serves to inform CMS in its review of the State's request to renew the waiver.

I. Health and Welfare of Waiver Participants

The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation. *Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9*

This assurance has been partially met by the State

Grievance and Appeal Process

During the on-site visit, the CMS team reviewed State, County Developmental Disabilities Program (CDDP) and brokerage grievance logs, and interviewed state staff, brokerage staff and management, Community Developmental Disabilities Program (CDDP) and advocates to evaluate the State's grievance and appeal system. The State delegates the majority of the grievance and appeal process to the CDDPs, brokerages, and providers, with the exception of level of care (LOC) determination appeals which are handled through SPD. The CDDPs determine eligibility for services, provides waiver recipients with information on their rights, refers eligible waiver recipients to the appropriate brokerage, authorizes the Individual Support Plan (ISP), determines eligibility for crisis funding and helps plan the crisis supports, assists in transferring waiver recipients when they move into new counties, and monitor the overall quality of service delivery. The brokerages employ the waiver recipients' personal agents who are responsible for ISP development, securing services and monitoring service provision and may serve as fiscal agents. During the two year review window for which the CMS team requested fair hearings records, the State had processed only six cases. The SPD staff stated that the reason the number was so low was that the State had delegated the grievance and appeal process to the CDDP level. Due to the exceptionally low number of appeal cases, the CMS team requested that the State produce evidence of complete grievances processed by the brokerages and CDDPs.

The State submitted additional information to CMS after the completion of the on-site review to serve as evidence of the delegated grievance process. The CDDP files reviewed by CMS revealed a great variation in the upkeep of complaint and grievance logs, ranging from CDDPs with several complaints where resolution had been documented to CDDPs that stated they had had no complaints. Several brokerages had grievance processes but, none of the brokerages submitted grievance files for the CMS review. Therefore, there is no evidence that any recipients utilizing brokerage services completed the appeal process available through the brokerages' internal grievance and appeal system. The absence of grievance documentation at the CDDP level highlights a critical breakdown in the State's grievance and appeal system and provides evidence that the delegation of the grievance and appeal process is insufficient to adequately protect the grievance and appeal rights of waiver recipients. During the advocate interview, participants stated that the grievance and appeal system was difficult to understand for recipients and their families. The low number of fair hearings resolved at the SPD level and the absence of any grievance files at the CDDP level support these statements. The lack of grievances and appeals also supports the necessity for the staff administering the LOC assessment or those developing and monitoring the ISP to document the review of the recipients' appeal rights on at least an annual basis. Due to the state and CDDP level lack of grievance and appeal documentation, the state is unable to track or trend complaints to assure health and welfare of the recipients served by the waiver.

CMS Recommendation: The State must submit a corrective action plan by June 1, 2007, that: documents a comprehensive strategy for training delegated staff on the grievance and appeal process; develops a strategy for ensuring state oversight of the delegated agencies in relation to the grievance and appeal process, including frequency of the oversight; and centralizes the

grievance data to enhance the State's ability to track resolution of grievances and appeals and identify trends.

State's Response: Attached to this draft response are copies of grievance and complaints showing outcomes and resolutions from counties selected to participate in the CMS Waiver Review.

Prior to CMS's review of the State's Comprehensive and Support Services Waivers the State had begun adjusting and clarifying the current process of advising consumers of their administrative hearings and appeals rights at the CDDP and Brokerage Level. Immediately following the review visit the State began expediting the process and the implementation has really taken on momentum.

At the annual Individual Support Plan (ISP) meeting, the Service Coordinator or Personal Agent responsible developing the plan will inform the consumer and their guardian or legal representative of the consumer's administrative hearings and appeals rights. They will sign a document stating that they have been informed of their rights to a hearing or appeal. This document is a permanent part of the ISP process. The appeals and administrative hearings rights will be discussed with the consumer annually. Additionally, any time the consumer's benefits are denied, terminated or reduced they will be given notice and advised of their administrative hearings and appeals rights.

SPD employees are training CDDP Managers and Brokerage Directors and their staff on this new process. SPD provided draft information packets to CDDPs and Brokerages at a recent conference. Information provided detailed the State's expectations for Notification of Rights, definitions of terms, CDDP and Brokerage policies and procedures for complaint processes, required administrative hearings processes, administrative review processes, and eligibility determination processes. SPD will schedule further trainings for the CDDPs and Brokerages once these draft materials have been given a final approval by SPD Administration. A copy of the above-mentioned training materials are attached to this response and a copy of the revised ISP document showing the new ISP agenda detailing the client's notification of the right to an administrative hearings and appeals.

Oregon Administrative Rule (OAR) 411-320-0020 defines "Grievances" as: "a formal complaint by the individual or a person acting on his or her behalf about any aspect of the program or an employee of the program." Complaints are defined by the same rule as: "an allegation of abuse of an individual; a grievance against a CDDP or CDDP subcontractor's contract, policies or procedures; or other significant problem or dissatisfaction with the CDDP or CDDP subcontractor that could impact individual(s) health and safety, or significantly impact community relations with the CDDP or the CDDP subcontractor."

OAR 411-320-0170, a copy of which is attached for CMS's review, governs grievance and complaint procedures in each CDDP. CDDPs are required to maintain a log of all complaints and grievances received regarding the CDDP or any subcontract agency providing services to consumers. The rule defines what must be included in the grievance

and complaint logs and how CDDPs must address all grievances and complaints. SPD Central Office staff, i.e. Regional Coordinators, will review CDDP grievance and complaint logs during field reviews and SPD Waiver Unit QA Staff will review the logs during on-site trainings, reviews, and technical assistance visits.

The SPD, Office of Developmental Disability Services (ODDS) will utilize an existing centralized database to track all administrative hearings requested for our MR/DD population. SPD will create a centralized database to track any grievances and complaints made by consumers against a provider, CDDP, or Brokerage that have elevated to the State level. By tapping into and utilizing the existing centralized database and creating a new centralized database, the State will be able to comprehensively track the number of hearings requests, grievances and complaints the State receives, the outcome of the hearings, grievances, and complaints, and identify any potential trends.

***Because the State has met CMS's requirements surrounding Abuse, Neglect, and Exploitation under this Section and to which CMS offered no recommendation, SPD respectfully requests that CMS change their findings to "<u>This assurance has been partially met by the State".</u>**

Final CMS Response: This assurance will be met upon CMS' receipt of a draft training schedule for the CDDPs and Brokerages and the submission of an overview of the new centralized database which will track any grievances and complaints made by consumers against a provider, CDDP, or Brokerage that have elevated to the State level.

<u>Abuse, Neglect and Exploitation</u>
The State has developed a standardized state-wide process for recording and tracking incidents of abuse, neglect and exploitation using a web-based application called the Serious Event Review Team (SERT) system. The SERT system provides: centralized reporting of serious events, including initial allegations of abuse; a linked computerized method in which to report serious events; a standardized format for tracking and documenting CDDP and SPD actions and outcomes; a longitudinal database from which to analyze state and local trends; and integration and review of serious events and significant licensing issues at both the State and local levels.

Allegations of abuse, neglect or exploitation are reported by providers or another party (family member, advocate, and/or friend) to either the CDDP or SPD which then enter the information into the SERT system. The determination is then made regarding whether or not a protective services investigation (PSI) is warranted. The PSI may be conducted by the CDDP's investigative staff, Office of Investigations and Training (OIT), local law enforcement, the Medicaid Fraud Unit or DHS child welfare, depending on which review would be most appropriate to the situation. The recommendations of the PSI are entered into the SERT system. The SERT team reviews the entered data, initiates action or recommendations for service quality maintenance.

The SERT team conducts monthly reviews of submitted data and submits a report to SPD. The report includes data analysis, an issue review, a review of actions taken and the outcomes of those actions.

CMS Recommendation: No recommendation

II. Plans of Care Responsive to Waiver Participant Needs

The State must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of plans of care for waiver participants. *Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7; Section 1915(c) Waiver Format, Item Number 13*

This assurance has been partially met by the State

Support Services Waiver- Plan of Care

Personal agents, who are employees of a brokerage, develop the recipient Individual Support Plan (ISP), which serves as the State's plan of care, utilizing person-centered planning. The ISP is developed by the recipient's personal agent and support team and is checked to ensure that the plan meets all the recipient's needs identified in the LOC assessment. The ISP documents: recipient goals; service provision in amount, duration and scope; recipient receipt of information regarding their grievance and appeal rights; a quarterly review of recipients waiver costs to ensure budget compliance and verify service delivery; recipient risk assessments; and case notes documenting personal agent activities. The ISP had a discussion field which was used to document differing opinions of team members during the care planning meeting.

CMS Recommendation: No recommendation

Comprehensive Waiver

The ISP is developed by a case manager who is an employee of a CDDP. The on-site review of ISP for the comprehensive waiver revealed: inconsistent documentation of recipient goals; and an absence of documentation verifying service provision and/or case manager to recipient contact. While on-site the CMS review team requested the state submit complete ISP for two individuals on the Comprehensive waiver. The state submitted the ISP within the thirty day time frame. A review of the submitted ISPs resulted in a complete document which included the ISP, progress notes, claim records, provider documentation, safety protocols, physician orders, medication administration records, and recipient activity logs.

CMS Recommendation: The State must ensure that sufficient documentation is maintained in the recipient ISP to produce evidence of service delivery, service monitoring, freedom of choice, and provision of grievance and appeal rights. The State must submit to CMS its policies and procedures for monitoring the Comprehensive Waiver's ISPs to ensure they are comprehensive in scope by June 1, 2007.

State Response: During the on-site review, CMS was provided with quarterly snapshots of the case files for the 35 consumers chosen to participate in the review. The State used this method due to the voluminous amounts of paper that would have been generated by copying each of the entire 35 files and the enormous expense incurred by the counties to copy and send each complete file. The reviewers from CMS requested that the State send complete case files for 2 Comprehensive Service Waiver recipients to them within 30 days

from the date of the on-site review. The State complied with this request within the allotted time frame by sending two complete files containing 18 months of Service Coordinator's case notes, Medication Administration Record (MAR), Treatment Administration Record (TAR), provider documentation and progress notes, protocols, the ISP, claims records, physician orders, and activities logs.

The State believes that the service delivery proof CMS is requesting be documented in the consumer's case file is in fact present in the majority of, if not all, case files. As CMS stated in their findings in the draft report on this issue, "While on-site the CMS review team requested the State submit complete ISP for two individuals on the Comprehensive waiver. The State submitted the ISP within the thirty-day time frame. A review of the submitted ISPs resulted in a *complete document* (emphasis added) which included the ISP, progress notes, claim records, provider documentation, safety protocols, physician orders, medication administration records, and recipient activity logs."

The State does concur that the documentation in the file may not be transparent enough to identify certain individuals referenced as specific service providers. For example, instead of a Service Coordinator's progress note in a case file stating, "Spoke with Bob at ARC today. Bob says Jimmy is following directions well." It would be more informative and show conclusive proof to state, "Spoke with Bob from ARC today. Bob is Jimmy's supervisor at his employment program. Bob says Jimmy is taking directions well, completing assigned tasks, and not exhibiting behaviors."

In an attempt to respond to CMS's recommendation regarding documentation of proof of service delivery the State will issue a Policy Transmittal (the Department's method of relaying policy or practice changes) to the CDDPs across the State. The Policy Transmittal will advise Service Coordinators to provide more detail in their case notes to include identifying service providers, agency names, and other relevant details. We will include examples of appropriate narrative format and minimum narrative requirements to assure that appropriate proof of service is available in the consumer's case file. The State will submit a corrective action plan to CMS detailing the outline of the Policy Transmittal June 1, 2007.

The State has responded to CMS's above recommendation concerning notification of consumer's right to an administrative hearing and appeal in Section I, Health and Welfare of Waiver Participants.

Final CMS Response: This assurance will be met upon receipt of the Policy Transmittal.

Technical Assistance

The State provides technical assistance to the team responsible for development of the ISP through the Oregon Technical Assistance Corporation (OTAC). OTAC will provide ISP team members with training or technical assistance on any aspect of the ISP process. The personal agents, case managers and support specialists are provided with a resource chart which includes contacts for experts in the following areas: nursing; client advocacy; guardianship and legal

rights; medical and behavioral issues on the ISP; contracts; licensing issues; and administrative rule.

CMS Recommendation: No recommendation

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers. *Authority: 42 CFR 441.302; SMM 4442.4*

This assurance has been met by the State

Assurances that the standards of any state licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver.

The State has policies and procedures in place that demonstrate its process for ensuring all waiver services are provided by qualified providers. Oregon Administrative rules are the standards governing both licensed and certified programs and form the basis for the State's monitoring visits and license renewals. The State performs a 100 percent licensing reviews of providers of waiver services based on their certification cycle, which is annual or bi-annual depending on the provider.

Reviews are scheduled based on the States "License Renewal Due Report." This report tracks all providers and their license renewal due date. The license renewal cycle is closely tracked and reviews are schedule to ensure enough time to conduct the review, prepare Continuation Action Plans (CAP) when necessary and act upon the license renewal. The State's review tool is based on Oregon Administrative Rule requirements and the State surveyor determines whether each rule is met or not. If deficiencies are found and a requirement is not met, a Corrective Action Plan (CAP) is required of the provider. Licensure is withheld unless a CAP is provided and approved by the State.

The State's review files are well documented. Each Administrative Rule requirement is reviewed and documented by the reviewer and forms the basis of any CAP requirement. Included in the review are training requirements. Each provider is required to possess a certain amount of training annually or during the license cycle. Provider files are reviewed to verify requisite training requirements are met. If deficiencies exist in this area, a CAP is required to ensure proper training is received.

Monthly Monitoring by the CDDPs
The County Developmental Disability Programs (CDDP) case managers monitor all DD licensed and certified foster homes and 24-hour residential sites once per month. The visit serves to check the quality of the recipients' care and the ability of the facility to meet the recipient's needs. The state has developed a monthly checklist for these visits to be completed by the CDDP staff.

CMS Recommendation: No recommendation

Brokerages/County certification of providers
The brokerages and County staff review contracted provider qualifications. A tickler system is used by these entities to assure that providers meet all dates for certification. All providers are required to have background checks, which are state-wide, except in the case where the provider has lived outside the State in the last three years. In that case a FBI check is required.

CMS Recommendation: No Recommendations

Adequate standards exist for all types of providers that provide services under the waiver.
The State clearly outlines the requirements for each of its waiver providers in Oregon Administrative Rule (OAR).

CMS Recommendation: No Recommendation

IV. State Conducts Level of Care Need Determinations Consistent with the Need for Institutionalization

The State must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care need consistent with care provided in a hospital, NF, or ICF/MR. *Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5*

The assurance has been partially met by the State

Level of Care (LOC) Evaluation Instruments
The documents reviewed confirm State utilization of the approved LOC assessment tool (Title XIX form) submitted in the waiver application and that individuals with the appropriate level of training were administering the assessments. Initial LOC assessments are reviewed by the D&E Coordinator at SPD as stated in the approved waiver.

The CMS team found that previously approved Title XIX form was not an effective instrument in practice. The Title XIX form is only signed by the recipient during the initial assessment, when they signed the form acknowledging that they had been provided information on freedom of choice and their grievance and appeal rights. In the case of the Comprehensive Services waiver, the State was unable to produce evidence that customer would have been informed of their appeal rights or freedom of choice after the initial assessment. For many waiver recipients this may have resulted in several years passing since the customer received information on his/her rights. The CMS review team found evidence in the Support Services waiver documenting the review of these rights at least annually by brokerage staff. There was limited evidence of annual customer participation in the LOC re-determination process. Additionally, recipient LOC changes were difficult to follow on the Title XIX form; changes were written in the margins of the form and were not consistently dated.

CMS Recommendation: CMS strongly recommends that the State revise the current Title XIX form to clearly document annual recipient (or guardian) participation in the LOC process, changes to LOC, and provision of information to the client regarding both freedom of choice and grievance and appeal rights.

State Response: CMS stated above: "The documents reviewed confirm State utilization of the approved LOC assessment tool (Title XIX form) submitted in the waiver application and that individuals with the appropriate level of training were administering the assessments. Initial LOC assessments are reviewed by the D&E Coordinator at SPD as stated in the approved waiver." The State is utilizing the LOC assessment tool previously approved by CMS and requests that the findings on this issue be changed to "This assurance has been met by the State."

SPD Central Office and field staff do agree with CMS's finding that the current LOC form is cumbersome. Beginning in the fall of 2006, SPD staff began revising the current Title XIX LOC form and plan to introduce the revised form as a pilot project to the CDDPs in the fall of 2007. The revised form is a streamlined, user-friendlier version of the existing form and allows more room for the Service Coordinator's signature. The State is also adding more comprehensive and detailed instructions for completion of the form.

SPD intends to submit the new form to CMS's Seattle Regional Office representatives for approval before soliciting CDDP participation and implementing the pilot project.

As stated above in the State's response to Section I, Health and Welfare of Waiver Participants, SPD has begun implementing a new process to assure that consumers are advised of their right to an administrative hearing and appeal during the annual ISP meeting.

Final CMS Response: The assurance will be met pending the receipt and review of the revised Title XIX form.

Freedom of Choice

Freedom of choice was well documented in the Support Services waiver in both the ISP and LOC assessment (initial assessment only). The documentation of freedom of choice on the Comprehensive waiver was only found to be present in the initial LOC determination, and was not located in the ISP. The CMS review team found the documentation of freedom of choice to be insufficient on the Comprehensive waiver as in most cases the date documenting the choice was several years old.

CMS Recommendation: The State must establish a mechanism for the Comprehensive waiver to ensure recipient Freedom of Choice is reviewed and documented on an annual basis with the recipient (or their legal guardian, if applicable). Please submit a corrective action plan to CMS no later than June 1, 2007.

State Response: The State offers consumers the choice of community-based and ICF/MR services at the initial Level of Care assessment. The choice is offered again when a

consumer turns 18, or if an individual terminates from community-based care and becomes waiver eligible later. The Code of Federal Regulations (CFR) does not require the annual offering of choice between community-based and ICF/MR.

Final CMS Response: This assurance has been met.

LOC assessments are conducted on time (at least every 12 months)
The CMS team found evidence that LOC assessments were conducted on time. However, interviews with care managers and a review of the state's training manual revealed that the LOC assessments were not always done, or expected by state staff to be done, face-to- face. Care managers stated that they were very involved in the recipient's life and therefore a face-to-face assessment was not necessary.

CMS Recommendation: The annual LOC assessment must be conducted face-to-face to ensure the health and welfare of the recipients. Please submit a corrective action plan to CMS by June 1, 2007.

State Response: The State concurs with CMS's recommendation that annual LOC assessments be conducted face-to-face. CDDP Managers will be informed that all Comprehensive Services Waiver consumers' annual LOC assessments must be completed in-person at the same time as the consumer's annual ISP meeting. In the event the ISP meeting comes due prior the annual LOC assessment, the Service Coordinator will be required to complete the annual LOC assessment at the earlier ISP meeting.

Personal Agents (PA), employed by a Brokerage, assist consumers served under the Support Services Waiver. A consumer's PA is a member of the ISP team and is responsible for drafting the initial and annual ISP. A CDDP Support Specialist must review and authorize the ISP. The CDDP Support Specialist is also required to sign the annual LOC assessment.

The State is currently trying to determine the best way to facilitate the completion of face-to-face annual LOC assessments for consumers in Support Services. This will involve discussions with CDDP managers to decide the best course of action for implementation of this process. The State will have a corrective action plan drafted by June 1, 2007, detailing the implementation of both processes.

Final CMS Response: This assurance will be met pending the approval of the corrective action plan.

V. State Medicaid Agency Retains Administrative Authority Over the Waiver Program

The State must demonstrate that it retains administrative authority of the waiver program and that its administration of the waiver program is consistent with its approved waiver application. *Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7*

The State substantially meets this requirement

Quality Management Strategy

The State has several excellent components of a fully developed Quality Management Strategy. However, CMS recommends that the State develop a comprehensive strategy which not only combines the various components, but adds the following major task associated with improvement. This strategy should to reflect a "Big Picture" approach and analysis of the entire waiver system. For more detailed guidance the State is referred to the new CMS Instrument for Reviewing HCBS waiver applications, November, 2006.

Recommendations:

1. Administration/Medicaid Agency: The State needs to specify the quality assurance protocols, frequency of monitoring, and monitoring functions delegated to the counties, brokerages. The strategy should specify the methods by which performance is measured and assessed.

2. Oversight and monitoring of the incident and abuse system as effects the developmental disability clients.

3. A centralized method for collecting data for analysis of grievance, appeals & fair hearing processes.

4. Outline the state's restraint procedures (environmental, chemical, or physical) and detail how the state ensures the safeguards are followed.

5. Describe the policy for medication administration and reporting incidents.

6. Define the roles and responsibilities of everyone involved in the waiver program, including at least:

Medicaid Agency
Counties
Brokerages
Participants
Families
Other State Agencies
Providers
Advocates

7. Develop a prioritized system to review audit findings, establish priorities and development strategies for remediation and improvement of identified deficiencies. Develop an evaluation format to measure the effectiveness of remediation and improvement activities.

8. The state needs to formally approve the QA systems of the counties, and the brokerages. There must be system for the state to monitor the implementation of these QA systems. The state should provide guidance to these entities on their requirements for a quality practice.

State Response:
1) Administration/Medicaid Agency: The State needs to specify the quality assurance protocols, frequency of monitoring, and monitoring functions delegated to the counties, brokerages. The strategy should specify the methods by which performance is measured and assessed.

SPD, Office of Federal Resource Reporting and Financial Eligibility (OFRRFE), Quality Assurance Unit staff will conduct periodic onsite reviews of all CDDPs to ensure that the terms of OAR 411-320-0040(9)-(13) are adhered to. The onsite review will include:

- **Review of the county's quality indicators and completed quality improvement (QI) activities;**
- **Review of the county's QA plan and timely implementation of the activities defined in the local QA plan;**
- **Evaluate the county's policies and procedures created to support the QA plan;**
- **Assess the CDDP's findings, corrective actions and impact of corrective actions that have been reviewed at a policy level in the county;**
- **Review the conclusions and recommendations from analysis of information gathered during the course of QA/QI activities; and**
- **Attend the county's local QA Committee meeting, time permitting.**

SPD's Support Services Staff (a.k.a. Staley Team) will continue to conduct annual field visits at brokerages as defined below in Staley Team Review .
2. Oversight and monitoring of the incident and abuse system as it affects the developmental disability clients.

SPD's Serious Event Review Team (SERT) will continue to meet monthly to discuss serious events occurring in the DD population. SPD's SERT Policy group meets on even numbered months and SERT Operations group meets on odd numbered months resulting in monthly SERT meetings.

SPD SERT will continue to review data, track trends and offer trainings to field offices and community partners when a risk or trend has been identified. For example, a 2006 study conducted by SPD showed that there were a significant number of falls resulting in injuries to our consumers reported in our SERT database. A result of the identification of this risk has been to add a question to the Risk Tracking Record to capture consumer information up front regarding falls.

SPD's Health Services Unit is also conducting trainings to educate community partners about the risk of falls and how we can prevent them in our MR/DD population.

The Office of Investigations (OIT) conducts a review of the Protective Service Investigations (PSI) database concerning the MR/DD population. The findings are shared with the SERT team members at bi-monthly SERT meetings. This information sharing has resulted in reviews being done both of SERT data and OIT data to ensure that incidents are being entered consistently across both systems and we're identifying the types of incidents and potential trends.

The SPD Licensing Unit provides information regarding licensing issues at bi-monthly SERT meetings. This information is shared and utilized in much the same way as OIT's data information.

SPD's QA Unit staff will monitor each county's monthly SERT meeting minutes to identify possible trends occurring across the State or in specific geographic areas and to ensure that these meetings are being conducted in a manner consistent with the Department's expectations. We will also be conducting random pulls of SERT data and reviewing it for consistency and accuracy. If any inconsistencies or inaccuracies are identified, we will offer technical assistance and advice to the responsible individuals at the county level.

SPD QA Unit Staff will also identify training needs and, in early 2008, implement a mandatory annual SERT training for CDDP staff.

SPD's QA Unit staff have also begun posting the State SERT meeting minutes after a brief period of inactivity on the SERT website for counties to review.

3. A centralized method for collecting data for analysis of grievance, appeals & fair hearing processes.

This recommendation has been addressed above in Section I., Health and Welfare of Waiver Participants.

4. Outline the state's restraint procedures (environmental, chemical, or physical) and detail how the state ensures the safeguards are followed.

Please see attached copies of Oregon Administrative Rules governing restraint procedures. The rules are our State's policies governing such matters.

The SPD's Service Coordinators Basics Training and policy on use of physical interventions is governed by Oregon Intervention System (OIS). The OIS physical intervention system follows a hierarchy of responses from least to most intrusive. Behavior plans should reflect which, if any responses are approved, and the conditions in which they may be used. Any behavior related restraint or intervention outside of OIS's approved list requires approval by the OIS Steering Committee.

In licensed or certified programs there are administrative rules governing restraints, incident reporting and medication administration in each service specific rule. SPD's Licensing Unit conducts licensing or certification reviews bi-annually in Residential

Homes, Employment and Alternative Services, and Supported Living Programs. Local CDDP or Regional employees conduct annual reviews of children and adult foster homes. Case managers receive and review incident reports as outlined in the CDDP rule and monitor both medications and restraints at least quarterly depending on the size of the program. The Licensing Unit will do a review outside of their normal schedule when a complaint about medication or restraint usage is received.

In Support Services, medication and restraint issues are reviewed during SPD's Licensing Unit review of a brokerage or a provider organization. Brokerages and provider organizations are certified every 2 years and the Support Services Staff also does regular field reviews on rule compliance.

5. Describe the policy for medication administration and reporting incidents:

Please see the attached Oregon Administrative Rules governing medication administration and reporting incidents.

6. Define the roles and responsibilities of everyone involved in the waiver program, including at least:

Medicaid Agency
Counties
Brokerages
Participants
Families
Other State Agencies
Providers
Advocates

The State will provide a comprehensive outline of the roles and responsibilities of the above-listed individuals by June 1, 2007.

7. Develop a prioritized system to review audit findings, establish priorities and development strategies for remediation and improvement of identified deficiencies. Develop an evaluation format to measure the effectiveness of remediation and improvement activities.

In 2007, SPD, OFRRFE, QA Staff will establish priorities and develop strategies for remediation and improvement of identified deficiencies. The QA staff intends to accomplish this by conducting on-site field reviews of each CDDP's QA system as described above in Number 1, and offering technical assistance and training to CDDPs.

Currently, Multnomah, Marion, Clackamas, Lane, and Washington County QA Coordinators meet quarterly to discuss issues, concerns and potential trends in their respective counties. These counties are the five most populated counties in Oregon. They utilize each other's experiences to enhance their own programs. Staff members from the

State's QA Unit attend these meetings at the invitation of the counties. This is an excellent tool for the State staff to learn what is happening on the "front lines" at the county level and approach SPD management and administration with concerns and ideas for quality improvement activities.

The QA Unit will approach QA Coordinators throughout the rest of the State to discuss the possibility of "partitioning" the State into regional areas of like-sized counties and implementing meetings such as the five urban counties have done. This would offer all counties the opportunity to discuss things that may be happening or have happened in their counties with peers throughout the State. This would essentially create a network and support system for counties to begin utilizing each other, State staff and their experiences to produce more comprehensive QA systems.

8. The state needs to formally approve the QA systems of the counties, and the brokerages. There must be system for the state to monitor the implementation of these QA systems. The state should provide guidance to these entities on their requirements for a quality practice.

Oregon Administrative Rule 411-320-0040(9) governs CDDP practices surrounding their Quality Assurance Systems. A copy of the rule is attached for your review. CDDPs are required to update their QA plans annually and at any time a change is made in their QA system. These updated plans are vetted through the Department. The Department offers insight and recommendations as to how a plan would be more effective or changes that need to be made to the plan to support the Department's QA plan and requirements. QA plans are also a topic of discussion at semi-annual, statewide QA Coordinator meetings. Best practices and plan weaknesses are discussed and suggestions are offered. The Department also has an "open door" policy with the CDDPs and their QA staff. At anytime the CDDPs or QA staff have questions or concerns regarding their QA plans or QI activities they may contact the State QA Unit for support and guidance. The Department will also be implementing a schedule for periodic visits to CDDPs to look at their QA systems as described above under our answer to recommendations in Number 1.

Quality Assurance plans at the Brokerages are reviewed by State Support Services Staff. There is a contractual requirement for Brokerages to send their QA plan and associated documentation. Support Services Staff look at some aspects of each Brokerage's internal QA practices by reviewing policies and procedures and then determining if they are being followed in specific situations. Additional follow up is done by the individual State liaisons with their respective brokerages.

Although unique, brokerages are simply another type of service provider in our system, not unlike an agency that provides residential or employment programs. They are not given a status above other providers, are not on a par with CDDP's and are treated no differently than other provider entities regarding QA expectations.

Oregon Administrative Rule 411-340-0150 (10) governs Quality Assurance Plans at the Brokerage level. A copy of the rule is attached for your review.

Final CMS Response: This assurance will be met upon the receipt of the defined roles and responsibilities of the following entities involved in the waiver program: Medicaid Agency; counties; brokerages; participants; families; providers; advocates; and other State Agencies.

Staley Team Review

The Staley Team field review occurs on an annual basis. The SPD central office team pulls a 5 percent random sample of Support Service waiver participants enrolled in each brokerage. The SPD team members conduct an on-site review which includes a review of: the LOC assessments, plans of care, customer goal summaries, the Basic Supplemental Criteria Inventory, progress notes, provider reports and documentation, correspondence, provider invoices, annual reviews, incident reports, provider expenditure logs, employee job descriptions, and provider service agreements. The review findings are collected and aggregated at the SPD central office. The review focus aligns itself with the CMS six assurances for HCBS waivers.

CMS Recommendation: No recommendation

VI. State Provides Financial Accountability for the Waiver

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program. *Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10*

This assurance has been met by the State

The State is currently in the process of designing a new MMIS system which will greatly enhance SPD's ability to track and report waiver finances. According to the State, the new system will become active in March 2008 and will provide the state with an enhanced capacity to audit the waiver finances. CMS is strongly encouraging each state to use the MMIS system to pay for services rendered. This is a claims based system which can be monitored by the state to validate that payments are made for Medicaid services and for Medicaid clients.

Support Service Waiver

Payments to providers of waivered services are documented in the State's Client Process Monitoring System (CPMS). An enrollment form is completed by the brokerage (#0375) for each individual receiving waiver services and submitted to the Mental Health and Developmental Disability Services Division (MHDDSD). The data from the form is entered into the CPMS database. Providers submit a request for payment through completion of the CPMS billing form. The billing form includes the recipient's name and Medicaid ID number, type of service received, dates of service, and the total amount billed for the service. The hard copy of the CPMS billing form serves as a receipt. The Support Services brokerage generates a check to the provider based on the services documented on the CPMS billing form. The services billed align with the services authorized on the recipient's ISP. The brokerages review the utilization reports monthly and costs annually, referring any discrepancies up to SPD. CPMS documents both waivered and non-waivered (state general fund) services.

CMS Recommendation: No Recommendation

Comprehensive Waiver

Residential and Day Habilitation Services (Adult and Children's group homes, supported living, prevocational and supported employment services)

To document payments to providers of waivered services, SPD central office and providers maintain monthly reports by services by provider which are generated from CPMS. CPMS documents contract utilization and provides financial information for auditing contract performance. The CPMS enrollment form supplies information and data about an individual and tracks delivery of service. CPMS produces the following reports from this data: Client Termination and Service Adjustment Reporting form; Client Offset Report (residential habilitation only); Provider Financial Statements; and Fiscal Year reports. The reports include the recipient name and Medicaid ID number, dates of service, and total amount billed for each individual. The CDDPs and providers receive the reports on a monthly basis. SPD maintains the information in a computerized database and reconciles the information monthly and annually to provider payment information maintained in SPD's accounting records. The document trail tracks all waiver funds to the recipients.

Non-Relative Foster Care (Adult and Children)

Non-Relative Foster Care payments are made through SPDs Community-Based Care Payment System (CBC). The CBC includes an automatic payment authorization form (the 512) that acts as an agreement between the provider and the state regarding the services that the individual is to be provided, the amount of compensation the provider will receive for providing the service, and the source of funds. The 512 is generated monthly and includes: the provider name, address, and provider number; summary by individual of the current room and board amount; the service amount; any recipient contribution; and the amount the state will pay. All service payments are combined into one check that is issued to the provider. The Remittance Advice Form provides a detailed summary of each of the payments included in the check, all adjustments to that payment and a year-to-date summary of payments are provided.

In-Home Supports; Environmental Modifications; Specialized Medical Equipment and Supplies; Respite; Family Training; Physical, Occupational and Speech Therapy

These services are paid through the CPMS system outlined in the Support Services Waiver section above.

Transportation Services

Individuals receiving waivered transportation services are enrolled in CPMS. Monthly CPMS reports document the names of individuals served, Medicaid D number, dates of service and total amount billed. Payment for transportation services is based on the amount specified in the contract between SPD and the CMHP.

Support Services and Comprehensive Waiver

Payments to providers for prescribed medications, laboratory, dental, hospital, physician, or other services paid with Title XIX funds, outside of waiver funds, are made and monitored by the State's MMIS system.

CMS Recommendation: No recommendation

Documentation of Service Provision

The CMS conducted ISP reviews for both the Support Services and Comprehensive waiver. The review of the ISP associated with the Support Services waiver were found to be thorough with appropriate documentation which provided evidence of personal agents monitoring to ensure service provision. A review of the Comprehensive waiver case notes found insufficient documentation to assure that services billed for were actually delivered or that the service provision was being actively monitored.

CMS Recommendation: CMS is requesting a corrective action plan documenting how the State will ensure that case notes for the Comprehensive waiver provide sufficient documentation and evidence of care managers monitoring of service provision. Please submit the corrective action plan to CMS by June 1, 2007.

State Response: The State addressed CMS's recommendation of enacting a method to ensure case notes reflect proof of service delivery in the above-listed Section II, Plans of Care Responsive to Waiver Participants Needs.

Final CMS Response: This assurance will be met upon receipt of the Policy Transmittal.

Promising Practices

The CMS review team would like to acknowledge the State of Oregon for a number of promising practices identified during the course of the on-site review. The State has successfully implemented person- centered care planning. The ISP used in the Support Services waiver effectively reflects a comprehensive approach to care planning that focuses on the recipient's goals. The review team was impressed by the State's Risk Tracking Record which is utilized as part of the development of the recipients ISP. The tool identifies which factors put the recipients' health and safety at risk and outlines protocols for reducing identified risks. The tool also informs the recipient's providers about protocols in place to address recipient risks. The State has also funded a Quality Assurance (QA) FTE for each of its counties. The QA FTE works to carry out quality assurance activities at the local level which align with SPD's statewide policy.