Part 1 – Systems Assessment and Gap Analysis

The Oregon Department of Human Services (DHS) is Oregon's umbrella agency for statewide health and human services and is the single state Medicaid Agency. In 2001, DHS merged program elements that serve seniors and people with physical disabilities with those that serve people with developmental disabilities into one program division - Seniors and People with Disabilities (SPD). Both groups remain grounded in a philosophy of individual choice, person-centered planning, community integration and inclusiveness. Stakeholders, including participants, families, providers and advocates play an important role in program design and implementation. Local design and control are fundamental to both systems.

Oregon uses a one-stop shop approach to determine eligibility and to access benefits such as food stamps, health plan, and housing and long-term care services. Seniors and people with physical disabilities access services through an Area Agency on Aging in Oregon's urban counties, or through a state field office in rural Oregon. People with developmental disabilities access services through county government. SPD provides medical and long-term services and supports, through both Medicaid and state general fund resources, to seniors, to people with disabilities 18 years of age and older, and adults and children with developmental disabilities.

Current Long-Term Care Support Systems

Oregon's home and community-based long-term care service system is built on the principles of self-direction and self-determination. Services can be provided in community group homes, residential care facilities or foster homes, or in the person's home.

In-Home Programs

SPD currently provides personal assistance services to approximately 12,000 seniors and persons with physical disabilities in their own homes. Services to these individuals in the in-

home program are provided by more than 11,000 private individuals, employed and directly supervised by the client, who have demonstrated their capability to perform the tasks that are authorized through direct observation, formal training, life experiences, or a previous employment experience. Once a person has been determined eligible for the Home and Community Based Waiver and requests that services be provided in their own home, the person and the case manager develop an individual care plan using the Client Assessment/Planning System (CA/PS) tool. Through the CA/PS assessment, the client identifies the amount and scope of services needed and any natural supports that are currently providing services, and then generate a support plan that authorizes staff and services to be purchased.

The majority of in-home services are provided through Oregon's Home Care Worker program in the Aged and Physically Disabled 1915 (c) Waiver. In this program, the client is authorized to hire an employee, known as a homecare worker (HCW), to assist them with activities of daily living. The case manager assists the client with recruitment and retention, and the state pays the provider, and remits required withholdings. The client is the employer and directs the homecare worker in all tasks they are authorized to do. In 2001, a constitutional amendment created the Home Care Commission for the purpose of developing worker qualifications, developing a Home Care Worker Registry, and acting as the employer of record for purposes of collective bargaining. The first collective bargaining agreement was signed in 2003, providing Home Care Workers with health benefits, higher wages and workers compensation.

"Independent Choices" is a "cash and counseling" 1115 demonstration waiver. Three hundred seniors and people with physical disabilities in this demonstration manage both the cash benefit and the provision of their home and community based services. As part of the renewal of

the Independent Choices program, Oregon plans to request that it be converted to a service under Section 1915(j) of the Social Security Act, and that the program be available statewide.

Approximately 4,000 adults with developmental disabilities also receive in-home services through the Support Services program, authorized by a 1915 (c) Support Services Waiver. This program was developed in response to legal actions filed as a result of long wait lists. The Support Services program is an entitlement program for any person with a developmental disability over the age of 18. Support services are in-home or other personal supports that assist an individual to live and work in their own home and community. Examples of support services include in-home staffing to assist with personal care; respite care in or out of the home; job coaching; and activities designed to assist an individual to participate in other social or recreational aspects of community life.

Oregon funds a Family Support program for children with developmental disabilities using state general funds. Approximately 1,500 families receiving these services; 60% of the funds are spent as respite care.

Group Living Programs

24-hour congregate residential community-based care settings provide alternatives to institutional or nursing facility care when seniors and people with disabilities are unable to live independently in their own homes. Settings available for Oregon seniors and people with physical disabilities include:

- Adult Foster Care - Services are provided in neighborhood residential home settings licensed for five or fewer unrelated people. Services include assistance with activities of daily living and behavioral supports if needed, medication oversight, and social activities. The primary caregiver usually lives in the home. Specialized homes have been

developed that serve people with Traumatic Brain Injuries (TBI) and those with high medical needs or AIDS. Several homes have been developed for people who need ventilator care.

- Residential Care Facilities - Facilities are licensed 24-hour care settings serving 6 or more residents. Facilities range in size from 6 beds to over one hundred. Services include assistance with activities of daily living and behavior supports, medication administration, and social activities.
- Enhanced Care Services - Enhanced Care Services are specialized 24-hour programs in licensed care settings that provide assistance with activities of daily living, nursing care, medication management, intensive behavioral supports and onsite mental health consultation for seniors and people with physical disabilities who have additional mental health needs. These programs combine funding from SPD and from the Department's Addiction and Mental Health Division.
- Assisted Living Facilities - Facilities are licensed 24-hour care settings for 6 or more residents that include private apartments with fully accessible bathrooms.
- Providence Elder Place - Providence Elder Place is a capitated Medicare/Medicaid Program of All-Inclusive Care for the Elderly (PACE), which provides an integrated program for acute and long-term care services.

Settings that are available for people with developmental disabilities include:

- Community Residential Programs - These residential programs are defined as 24-hour group home care for individuals aged 18 and over, with a developmental disability. These programs are contracted through local county government and are licensed by SPD. In most cases, people live in homes that are designed for five or fewer people

living in a home, with staff that come into the home and work on a shift schedule. Most people with developmental disabilities enrolled in residential services funded by SPD receive SSI or Social Security payments. The amount they can pay for rent is limited to a portion of their SSI or SSA room and board allowance. This amount is often too low to secure safe and appropriate housing, and service payments to providers may not be used to pay rent. Consequently, SPD supplements the rent payments based on actual and approved cost of housing.

- Children's Residential Care- SPD provides residential care for children with developmental disabilities through foster care, proctor care and community residential group homes. The child must have a diagnosis of mental retardation or developmental disability and need out-of-home placement due to a crisis that puts the child or others in imminent risk. The child may be committed to the state for care and custody through the child welfare program or the family may request voluntary services.
- State Operated Community Program (SOCP) - The State Operated Community Program (SOCP) is a 24-hour community residential care program for a small number of people who have a developmental disability and have intensive support needs due either to a medical or behavioral condition. There are 33 homes, serving five or fewer people, located in eight counties. All employees of this program are staff of SPD. These homes must meet all state and federal requirements of both residential and employment programs for people with developmental disabilities. SOCP also provides short-term (up to 90 days) crisis and diagnosis services for up to five people at any given time.

Contract Nursing

Oregon's contract nursing program offers services to people with physical or developmental disabilities who are served in their own homes, or in small community living settings, like foster homes. Registered nurses provide monitoring and consultation to clients, and delegate nursing tasks to providers or other lay caregivers. The contract nursing program allows people who need regular nursing care to continue to live in their homes, or in home-like community settings.

Institutional Care

During the calendar year 2005, there were 140 Oregon nursing facilities with 12,452 licensed beds. Approximately 85% of these beds are actually staffed. The number of licensed beds has declined over time – in 1990, there were 15,395 licensed beds, and in 2005, 12,452 – a 19% decline. Medicaid is the single largest payer, accounting for 60.8% of total resident days in 2005. Statewide occupancy for licensed beds was 66.8%. There is one remaining Intermediate Care Facility for the Mentally Retarded – the Eastern Oregon Training Center. Average daily census through 2005 was 41.

What is in place and working to rebalance the State's resources?

Oregon initially offered long-term care services through nursing facilities (NF) and intermediate care facilities for the mentally retarded (ICFs/MR). Over time, it became evident that many consumers and their families could be better and more cost effectively served in alternative environments. In 1981, Oregon was the first state to secure a waiver under Medicaid's Home and Community Based Waiver Program (1915(c)). Oregon has led the nation, since 1981, in the development of lower cost alternatives to institutional care in both nursing and intermediate facility care. Home and community-based alternatives to institutional care emphasize independence, dignity and choice, and offer needed care and supports at lower cost

than medical models. Oregon's Medicaid funding in 2005 for services for seniors and people with physical disabilities is almost equally split between nursing facilities, community facilities and home care; yet, more than 80% of clients receive services in their own homes or in smaller community-based settings.

The result of Oregon's 25 years of rebalancing efforts has been a significant decline in nursing home admissions and the closure of all but one small ICF/MR. As recently highlighted in the Final Report of the Money Follows the Person Initiatives of the System Change Grantees[1], Oregon ranks first of the 50 states and the District of Columbia, in the proportion of Medicaid long-term care expenditures that are made for home care, and last among the 50 states and the District of Columbia in its nursing facility occupancy rate. Of approximately 30,000 seniors or people with physical disabilities supported by SPD, only 4,700 are living in nursing homes. And of the 11,500 people with developmental disabilities supported by SPD, only about 40 are living in ICF/MR homes.

Even with the progress described above, Oregon believes that there are additional people living in institutions who could benefit from additional rebalancing efforts. While each grouping will be described in more detail in Part 2 of the application, the groups include:

- Children with developmental disabilities in pediatric nursing facilities
- Seniors with end-stage dementia in nursing facilities
- Adults with physical disabilities in nursing facilities; and
- Adults with developmental disabilities in nursing and intermediate care facilities.

[1] United States, Department of Health and Human Services, Center for Medicare and Medicaid Services, Money Follows the Person Initiatives of the System Change Grantees, Final Report, RTI International, July 2006, 16-20.

Description of current funding mechanisms

CMS has defined MFP as "a system of flexible financing for long-term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change."[2] A major component of flexible financing is a "financial system that allows Medicaid funds budgeted for institutional services to be spent on home and community services when individuals move to the community."[3]

Oregon's long-term care expenditures are forecast using global budgeting techniques – that is, the long-term care budget is derived for all long-term care services provided by SPD. The Oregon Legislative Assembly meets biennially, in odd-numbered years. The Legislatively Approved Budget for long-term care services and supports for seniors and people with disabilities is almost $2.5 billion for the 2007-2009 biennium.

Assessment of systems of care, waivers and SPAs

SPD oversees all Home and Community-Based Care Waivers for seniors and people with disabilities, including developmental disabilities. Current waivers include the nation's oldest nursing facility waiver, granted in 1981; two model waivers; two home and community-based services waivers for people with developmental disabilities and an 1115 demonstration waiver of a "cash and counseling" model, "Independent Choices". The combination of administrative entities for services for seniors, people with developmental disabilities, and people with physical disabilities into a cohesive structure provides a solid base for the kinds of rebalancing activities envisioned in this grant application. A summary of services and care systems is found in the table below.

[2] Letter from CMS Director for Center for Medicaid and State Operations to State Medicaid Directors dated August 17, 2004.
[3] Money Follows the Person, 12.

Type	Eligible Population	Services Available	Care Settings
State Plan	People eligible for Medicaid	Oregon Health Plan (OHP); State Hospital (OSH); ICF/MR; Nursing facility (NF); Personal Care; Program of All-Inclusive Care for the Elderly (PACE); Contract Registered Nursing (CRN)	OSH, ICF/MR; NF; own home; assisted living; residential care; adult foster homes; adult day health centers
1915(c) waiver for aged and physically disabled	Seniors and people with physical disabilities; meet NF LOC; 300% SSI	OHP; Adult Day Health; Adult Foster Care; Residential Care; Assisted Living; Specialized Living; Home Delivered Meals; In-Home Services; Home Accessibility; Transportation; Community Transition	Adult Day Health Centers; adult foster homes; residential care, assisted living and specialized living facilities; own home and family homes
1115 demonstration waiver "Independent Choices"	Seniors and people with physical disabilities; meet NF LOC; 300% SSI; meet demonstration guidelines	OHP; Cash benefit	Own home and family homes
1915(c) model waiver for children	Children from birth to age 18 who live in the family home; hospital LOC; significant medical needs	OHP; homemaker; respite; home accessibility; transportation; specialized medical equipment and supplies; chore services; family training; PT; OT; speech, hearing and language services; special diets; translation; behavioral consultation	Family homes
1915(c) model waiver for children	Children from birth to age 18 who live in the family home; ICF/MR LOC; significant behavioral needs	OHP; homemaker; respite; home accessibility; transportation; specialized medical equipment and supplies; chore services; family training; PT; OT; speech, hearing and language services; special diets; translation; behavioral consultation	Family homes
1915(c) waiver for adults and children with developmental disabilities	Adults and children with developmental disabilities in out-of-home settings, or annual cost >$20,000; ICF/MR LOC; 300% SSI	OHP; respite; habilitation; home accessibility; transportation; specialized medical equipment and supplies; family training; PT; OT; speech, hearing and language services; in-home support services; crisis/diversion services	Own Homes; Family Homes; Community Residential Programs; SOCP
1915(c) waiver for adults with	Adults with developmental disabilities who do	OHP; homemaker; respite; habilitation; home accessibility; transportation; specialized medical	Own Homes; Family Homes

developmental disabilities	not live in homes/residences licensed or certified by state; ICF/MR LOC; 300% SSI	equipment and supplies; chore; PERS; family training; PT; OT; speech, hearing and language services; special diets; specialized supports; support services brokerages; emergent services	

Current Expenditures

All figures shown reflect the 2005-2007 Legislatively Approved Budget. (Client counts reflect the average number served each month; expenditures are total funds over the biennium[4].)

	Number in Nursing Facilities/ ICF/MR	**Expenditures**	**Number in Community Facilities**	**Expenditures**	**Number Served at Home**	**Expenditures**
Seniors and People with Physical Disabilities	4,900	$606,109,000	11,200	$414,476,000	12,300	$377,136,000
People with Developmental Disabilities	45	$23,339,000	5,500	$737,186,000	6,100	$71,803,000

Current efforts toward self-direction

In-home programs fully utilize person-centered planning and individual budgeting. In-home services are supported by extensive use of public and private fiscal intermediary services, which enhance the principles of self-direction and the implementation of individual budgets.

About 12,000 seniors and people with disabilities receive long-term care services and supports each month through Oregon's Home Care Worker program provided through the Aged and Physically Disabled 1915 (c) Waiver. In this program, the client is authorized to hire an employee, known as a homecare worker, to assist them with activities of daily living. The case manager assists the client with recruitment and retention, and the state pays the provider, and

[4] Client counts are rounded to the nearest hundred people; expenditures are rounded to the nearest $1 thousand. Expenditure amounts include anticipated client contributions.

remits required withholdings. The client is the employer and directs the homecare worker in performance and timing of all authorized tasks.

"Independent Choices" is a "cash and counseling" 1115 demonstration waiver. Three hundred seniors and people with physical disabilities in this demonstration manage both the cash benefit and the provision of their home and community based services.

About 4,000 adults with developmental disabilities receive in-home services through the Support Services program, authorized by a 1915 (c) Support Services Waiver. All support services must be developed through a Person-Centered Planning process that considers the strengths, capabilities, needs, and preferences of the individual. People who make up the individual's existing circle of support (family, friends, and advocates) and representatives from public or private service organizations providing services to the individual participate in this planning process. Support services are delivered by organizations called "support service brokerages". Brokerage organizations employ staff (Personal Agents) who assist enrolled individuals by developing an individualized support plan, obtaining available resources as necessary to implement the support plan, assisting the person, if needed, in hiring people or organizations to provide specific support services, and monitoring and evaluating the outcomes of delivered services.

Current diversion and transition programs

Oregon's long-term care system, for seniors, people with physical disabilities and people with developmental disabilities, is designed to divert people to community settings before they are placed in an institution. The goal is to provide services in the least restrictive setting, guided by the individual choices and preferences, while ensuring quality and individual well-being.

For seniors and people with physical disabilities, eligibility for long-term care services immediately provides access to the full array of both health and long-term care services and supports. Individuals are able to self-direct their care with the assistance of case managers who help define the best array of services and care settings. Individuals choose a care setting: their own home or the home of a friend or family member or a community setting like a small adult foster home, or a larger assisted living or residential care facility, based on their personal preferences and local availability.

For people with developmental disabilities, diversion often occurs due to a crisis. Local and regional services are used to stabilize an individual and their living setting rather than institutionalizing the person in the ICF/MR. Diversion occurs through support services programs. Eligible individuals receive services, tailored to meet their needs, through a Support Services Brokerage. Supports supplement, but do not supplant, those materials or services that are provided by others.

Shortcomings

Most of Oregon's seniors and people with disabilities who need an "institutional level of care" receive needed care and supports in their own homes or in community-based facilities, not in institutions. People with increasingly complex and challenging needs can be served, and served well, in non-institutional settings. Quality service for people with these needs requires the provision of wrap around packages of services – for example, families may need 24-hour access to nurse or other professional consultation. Adult foster home providers may need access to staffing agencies at a moment's notice. More formal patterns of care coordination may need to be put in place to ensure that clients, friends and family, long-term care providers, social service networks and acute care providers all focus on coalescing their efforts to ensure quality of life

and quality of care. SPD will use this grant to develop the necessary packages of services for the diverse populations transitioned by this grant.

Collaboration needed

Oregon's community based care system was built with the active engagement of providers, provider associations, local Area Agencies on Aging, local governments, other state agencies and consumer and advocacy organizations. The network continues to thrive today but this grant will increase the focus on critical areas such as housing, transportation, and mental health and addiction services. SPD will need to build statewide and local coalitions, in collaboration with the Oregon Housing and Community Services and local housing authorities, to develop effective strategies to address housing barriers. Additionally, the department will work with the Oregon Department of Transportation to address concerns around non-medical transportation and community involvement.

SPD will continue its partnership with nursing facilities, community-based care providers, the provider associations (Oregon Health Care Association, Oregon Rehabilitation Association, the Adult Care Providers' Organization and the Oregon Alliance of Senior and Health Services), local governments, the Home Care Commission, Area Agencies on Aging, County Developmental Disabilities Programs, County Mental Health Programs, the Governor's Commission on Senior Services, Oregon Council on Developmental Disabilities and other advocacy and consumer-focused organizations to develop systems and supports to effectively transition the identified populations from institutions to the communities.

Quality Assurance and Quality Improvement

Oregon has a robust quality assurance system for all individuals served in community settings. The basic quality assurance system includes three fundamental elements: standards,

monitoring and response activities. All parts of the service system have responsibility for quality assurance.

Standards: It is the state's responsibility to identify the standards for services, including determination of both the specific rules and the underlying values that form the foundation for services. In Oregon the values underlying the service system were made law in the 1980's and include integration, choice and independence. Oregon's licensing and quality of care rules incorporate these values.

Monitoring: This core function of quality assurance occurs at all levels of the service system. The state monitors the overall service system through licensing and certification reviews; reviews of service outcomes; reviews of complaints, and serious events; financial audits; and obtaining consumer satisfaction information. Service providers are responsible by rule to monitor their systems and make changes as indicated. Monitoring consists of a variety of methods for collecting and analyzing information. Consumers and individuals knowledgeable of the system are involved in monitoring by providing input and/or participating in analysis of information.

Response Activities: These activities are designed to check the status of service delivery, and respond quickly when corrective action is needed. Activities include technical assistance and training to enhance a provider's ability to deliver and administer services, providing in-home nursing supports if needed, working with the client to dismiss HCWs who are not providing quality care and providing emergency supports if needed.

Oregon statute requires SPD to develop monitoring and evaluation systems to ensure competent management, program quality and cost-effectiveness of community-based services. Competent management and program quality requires that individuals be protected from harm

(healthy and safe), that their rights as individuals and citizens are protected, and that services are provided through activities that support self-determination and full inclusion. SPD is actively working to enhance our current QA/QI systems to promote these outcomes.

State legislative changes and other needed changes

Oregon's statues already allow, and in fact encourage, community placements versus institutional settings. Both law and administrative rule maximize self-direction and individual choice. The department will fully brief the Legislature about the grant and will provide ongoing updates. Rule changes may be necessary to allow the department to implement new services models not currently defined. The department's global long-term care budget also assists in aligning services to the client's choice.

Part 2 - Demonstration Design

Phase One

Implementation of Phase One

Seniors and People with Disabilities proposes that Phase 1 of its rebalancing demonstration focus on approximately 40 children under the age of 21 who have lived in Oregon nursing facilities for six months or longer as of October 1, 2007. Specifically, we propose to transition a total of 40 children with either developmental disabilities as evidenced by a PASRR or who do not meet developmental disability criteria but have complex medical needs that are stable but may require registered nurse delegation services and oversight. Examples of this population include children requiring total assistance in all activities of daily living and who may have respiratory, neurological or feeding disorders, requiring tracheal, suctioning and/or gastostomy feeding and stoma care. Transition sites will primarily be located in Oregon's 2 largest urban areas – Portland and Eugene. Phase 1 participants will transition from nursing facilities to family homes or to medical foster homes, in which no more than 4 unrelated individuals reside.

Services to be offered to Phase 1 participants will include:

Qualified Home and Community Based Program (State Plan and 1915(c) services)	**Home and Community-Based Demonstration Services**	**Supplemental Demonstration Services**
• Homemaker • Home Accessibility • Chore Services • Specialized medical equipment and supplies • Personal Care • Foster Care • Contract Registered Nursing • Transportation • Community Transition • Family Services • Habilitation/ extended habilitation services • Respite	• Targeted Case Management	• Assistive Technology • Nutrition Services • Housing Related Services

Anticipated Waivers

The services to be offered through the Qualified Home and Community-Based Program are currently approved services in Oregon's 1915(c) waiver for people with developmental disabilities. SPD anticipates that we will request a model waiver to allow Phase 1 participants to live in their family homes where maximum self-direction can be exercised.

Increasing the dollar and percentage of expenditures for HCBS

Phase 1 participants currently reside in Oregon nursing facilities, at an average cost of almost $8,400 per month. While Phase 1 participants demonstrate regular need for nurse assessment and monitoring, they do not demonstrate the need for round the clock nurse availability that is shown by more nursing facility appropriate residents; rather, they demonstrate constant need for personal care support, person-centered activities and supervision by staff trained in physical care for activities of daily living. MFP allows SPD the opportunity to put together a package of Home and Community-Based supports such as a network of medical foster homes that will more appropriately meet these childrens' needs at a lesser cost than nursing facility care. SPD also believes that implementation of family directed care to the maximum extent possible in the delivery of Phase 1 services through the model waiver will lead to better outcomes for children and families and to greater satisfaction with both services delivered and quality of life. Once developed, SPD plans to make the Phase 1 service package available to all children who meet the targeting criteria up to the model waiver ceiling dependent on provider availability.

Benchmarks

Oregon strongly believes that most children who currently live in nursing facilities will be better served in the communities. We propose to start Phase 1 activities October 1, 2007, or earlier, depending on approval of our Operational Protocol. Oregon proposes to establish

benchmarks that transition all 40 Phase 1 participants by the end of the 2008 calendar year. Oregon proposes to reserve the right to transition Phase 1 participants more quickly if possible, but in no case will establish more than 40 individuals as Phase 1 demonstration participants.

Recruiting Participants

The department will work closely with families, nursing facilities, foster care homes, state child welfare and local developmental disability agencies, schools, community organizations, family training and support centers and community members to identify possible participants. The department will use its Client Assessment and Planning System (CA/PS) tool and the MDS to identify individuals who meet the Phase 1 targeting requirements.

The department will use person-centered approaches that will ensure that only those individuals who want to move to a community setting will participate. Due to the ages and significant levels of impairment of the children being selected for this demonstration, family members and legal guardians will play a critical role in determining if a child would prefer to stay in the institution or move to a community setting. Specialized case managers, trained in transition related services and issues and family interviewing will be used to approach children and families who may be likely candidates. Case managers will also be used to identify possible placements, develop risk mitigation strategies, such as assessing informal supports, and to coordinate other services such as housing, equipment, transportation and access to local and specialized medical services. Final transition plans will be made cooperatively with participants, family members, case managers and care providers. Nurses with training in pediatrics or community based medical care for fragile individuals will review final transition plans and will be actively involved in both the child's transition to their new care setting as well as on-going services.

Cross agency service delivery collaboration.

Oregon's extensive network of community-based care providers was built with the active engagement of providers, provider associations, local developmental disability programs, other state agencies and consumer and advocacy organizations. Child foster homes and group homes, serving 5 or fewer unrelated individuals, have been a mainstay of Oregon's long-term care system for children with developmental disabilities for over ten years. A number of Oregon families struggle to support their medically involved children with few in home supports, whether or not they receive Medicaid. Phase 1 of this grant will increase the focus on development of smaller foster home models that include more nurse monitoring than is traditional in the state's foster care settings as well as wrap around staffing availability as well as increasing supports to families that bring children home from nursing facilities. DHS will need to build statewide and local coalitions, in collaboration with the Community Developmental Disability Programs, Oregon Housing and Community Services and local housing authorities, to develop effective strategies to address housing barriers. The department will work with the Oregon Department of Transportation to address concerns around non-medical transportation. DHS will also actively partner with the Developmental Disabilities Council, Oregon Advocacy Center, the Oregon Foster Parents Association, Life Span Respite and other organizations and providers to develop and to help transition children and systems from institutionalization to community settings.

Services through the demonstration program

SPD intends that a full package of Medicaid home and community-based services under the model waiver remain available to Phase 1 participants following the year in which they receive services through the demonstration program. We expect that most Phase 1 participants will

continue to live in community residences of 4 or fewer; however, the full package of services available through the proposed model waiver will be available to Phase 1 participants should they choose to move to another residence. The waiver service package is included on page 9 of this application.

Quality Management Strategy

Oregon has a robust quality assurance system for all individuals served in community settings. The basic quality assurance system includes three fundamental elements: standards, monitoring and response activities. All parts of the service system have responsibility for quality assurance.

Standards: It is the state's responsibility to identify the standards for services, including determination of both the specific rules and the underlying values that form the foundation for services. In Oregon the values underlying the service system were made law in the 1980's and include integration, choice and independence. Oregon's licensing and quality of care rules incorporate these values.

Monitoring: This core function of quality assurance occurs at all levels of the service system. The state monitors the overall service system through licensing and certification reviews; reviews of service outcomes; reviews of complaints, and serious events; financial audits; and obtaining consumer satisfaction information. Service providers are responsible by rule to monitor their systems and make changes as indicated. Monitoring consists of a variety of methods for collecting and analyzing information. Consumers and individuals knowledgeable of the system are involved in monitoring by providing input and/or participating in analysis of information.

Response Activities: These activities are designed to check the status of service delivery,

and respond quickly when corrective action is needed. Activities include technical assistance and training to enhance a provider's ability to deliver and administer services, providing in-home nursing supports if needed, working with the client to dismiss HCWs who are not providing quality care and providing emergency supports if needed.

Oregon statute requires SPD to develop monitoring and evaluation systems to ensure competent management, program quality and cost-effectiveness of community-based services. Competent management and program quality requires that individuals be protected from harm (healthy and safe), that their rights as individuals and citizens are protected, and that services are provided through activities that support self-determination and full inclusion. SPD is actively working to enhance our current QA/QI systems to promote these outcomes.

Barriers to flexible use of Medicaid dollars

The department uses a global long-term care budget, which allows for flexible funding among services and also allows services to be tailored to meet the individual's needs. This has allowed Oregon to develop a robust child foster home system throughout the state. Foster Homes are generally required to provide comprehensive supports to their residents. However, people transitioning from facilities to the community, especially to smaller settings like foster homes or family homes, often face specific barriers that have not been met by Medicaid. Most importantly, neither the rates paid to foster homes, nor the services available to families, are commensurate with the level of care that is required. SPD intends to use the pre-implementation stage to assess provider capacity and to develop a model waiver service package as an alternative to nursing home care. Issues that are already identified include:

- Lack of Respite Funds and Resources: Child Foster Home rates are all-inclusive with a small fund of $100 per month identified for respite. Providers are expected to provide

care 24 hours a day 7 days a week and be available should the child be unable to attend school. Foster providers and families are also expected to independently locate and train their respite providers. Support to develop and train a network of medically skilled respite providers will be essential; staffing plans and reimbursement models need to be redesigned.

- Provider Supports: Models need to be developed to allow very small community providers and families to succeed. Models must include risk management interventions, access to 24-7 nursing, training and support to increase provider and family skill sets, and business and administrative support for foster home providers and families who hire in-home staff.

Specific barriers will be addressed on a case-by-case basis.

Information Systems

Oregon is in the midst of implementing a new Medicaid Management Information System (MMIS), scheduled to occur during the first calendar quarter of the 2008 State Fiscal Year. Information from the existing MMIS will be converted to the new MMIS, including all participant demographic and benefit package. Oregon will identify Medicaid and MFP participation eligibility prior to transition through the MMIS; and will track services eligible for the enhanced FMAP through the new MMIS in accordance with later CMS instruction. We will use our existing CA/PS tools, coupled with utilization and outcome reports from MMIS, to monitor quality of services post transition.

Phase Two

Implementation of Phase Two

Seniors and People with Disabilities proposes that Phase 2 of its rebalancing demonstration focus on approximately 300 seniors who have lived in Oregon nursing facilities for six months or longer as of January 1, 2008. Specifically, we propose to transition 300 seniors who have late stage dementia, as evidenced by dependency in three activities of daily living, one of which is cognition, and who need registered nurse assessment and monitoring at least weekly. Transition sites will be located throughout Oregon, but primarily found in the 42 Oregon cities that have a population of 10,000 or more. Seniors will be transitioned from nursing facilities to community-based residences in which no more than 4 unrelated individuals reside.

Services to be offered will include:

Qualified Home and Community Based Program (State Plan and 1915(c) services)	**Home and Community-Based Demonstration Services**	**Supplemental Demonstration Services**
• Personal Care • Adult Foster Care • Contract Registered Nursing • Transportation • Community Transition • Adult Day Health • Respite • Program of All-inclusive Care for the Elderly		• Assistive Technology • Nutrition Services • Durable Medical Equipment • Family Services • Housing Related Services • Hospice Services

Anticipated Waivers

Most services to be offered through the Qualified Home and Community-Based Program are currently approved services in Oregon's 1915(c) waiver for the Aged and Physically Disabled. At this time, SPD anticipates that no additional waivers will be necessary to transition Phase 2

participants, though the existing waiver may need amendment to allow for the continuation of respite services.

Increasing the dollar and percentage of expenditures for HCBS

Phase 2 participants currently reside in Oregon nursing facilities, at an average cost of more than $5,000 per month. While Phase 2 participants demonstrate regular need for nurse assessment and monitoring, they do not demonstrate the need for round the clock nurse availability that is shown by more nursing facility appropriate residents; rather, they demonstrate constant need for personal care support, person-centered activities and supervision by staff trained in Alzheimer's care. MFP allows SPD the opportunity to put together a package of Home and Community-Based supports that will more appropriately meet these seniors' needs at a lesser cost than nursing facility care. Once developed, SPD plans to make the Phase 2 service package available to all individuals who meet the targeting criteria dependent on provider availability.

Benchmarks

Oregon proposes to establish benchmarks that transition at least 75 Phase 2 participants in the 2008 calendar year; at least 100 Phase 2 participants on the 2009 calendar year; and at least 125 Phase 2 participants in the 2010 calendar year. Oregon proposes to reserve the right to transition Phase 2 participants more quickly if possible, but in no case will establish more than 300 individuals as Phase 2 demonstration participants.

Recruiting Participants

The department will work closely with nursing facilities, foster care homes, local agencies, Area Agencies on Aging, ombudsmen, community organizations and support centers, community members and family to identify possible participants. The department will use its

Client Assessment and Planning System (CA/PS) tool and the MDS to identify individuals who meet the Phase 2 targeting requirements.

The department will use person-centered approaches that will ensure that only those individuals who want to move to a community setting will be asked to participate. However, due to the significant level of impairment of the individuals being selected for this demonstration, it is likely that family members will also play a critical role in determining if a person would prefer to stay in the institution or move to a community setting. Specialized case managers, trained in transition related services and issues and in effective communication with people with dementia, will be used to approach individuals who may be likely candidates. Case managers will also be used to identify possible placements, develop risk mitigation strategies, such as assessing informal supports, and to coordinate other services such as housing, transportation and access to medical services. Final transition plans will be made cooperatively with participants, family members and care providers. Nurses with training in Alzheimer's care will review final transition plans and will be actively involved in both the senior's transition to their new care setting as well as on-going services.

Cross agency service delivery collaboration.

Oregon's extensive network of community-based care providers was built with the active engagement of providers, industry associations, local Area Agencies on Aging, other state agencies and consumer and advocacy organizations. Adult foster homes, serving 5 or fewer unrelated individuals, have been a mainstay of Oregon's long-term care system since the 1980s. Phase 2 of this grant will increase the focus on development of smaller foster home models that include more nurse monitoring than is traditional in the state's community settings as well as wrap around staffing availability. DHS will need to build statewide and local coalitions, in collaboration with the Oregon Housing and Community Services and local housing authorities,

to develop effective strategies to address housing barriers. The department will work with the Oregon Department of Transportation to address concerns around non-medical transportation. DHS will also actively partner with the Governor's Commission on Senior Services, the Adult Care Provider Association, the Alzheimer's Association, and other organizations and providers to develop and to help transition individuals and systems from institutionalization to community settings.

Services through the demonstration program

SPD intends that a full package of Medicaid home and community-based services remain available to Phase 2 participants following the year in which they receive services through the demonstration program. We expect that most Phase 2 participants will continue to live in community residences of 4 or fewer; however, the full package of services available through the Home and Community-Based Services Waiver for the Aged and Physically Disabled will be available to Phase 2 participants should they choose to move to another residence. The waiver service package is included on page 9 this application.

Quality Management Strategy

Quality Management strategies and systems will be implemented in accordance with the Quality Management Provisions of Oregon's CMS-approved 1915(c) Home and Community-Based Comprehensive Services Waiver for the Aged and Physically Disabled. Additional discussion is found on pages 20 and 21 of this application. In addition, measures will be developed specific to people with dementia in the domains of quality of life and quality monitoring.

Barriers to flexible use of Medicaid dollars

The department uses a global long-term care budget, which allows for flexible funding among services and also allows services to be tailored to meet the individual's needs. This has allowed Oregon to develop a robust adult foster home (AFH) industry. Foster Homes are generally required to provide comprehensive supports to their residents. However, people transitioning from facilities to the community, especially to smaller settings like foster homes, often face specific barriers that have not been met by Medicaid. Most importantly, the rates paid to foster homes, even with a tiered reimbursement model based on assessed client needs, are not commensurate with the level of care that is required. SPD intends to use the pre-implementation stage to assess provider capacity and determine if special rates are needed for the identified populations. Issues that are already identified include:

- Lack of Respite: Foster Home rates are all-inclusive. Providers are expected to live in the home and provide care 24 hours a day 7 days a week. Substitute care is allowed for very short periods of time at the provider's expense. The emotional and physical demands of caring for high needs clients cannot be met by a single person. Payment rules and/or reimbursement needs to be redesigned.
- Case Management and monitoring: High need clients require more than annual service assessments and crisis management in order for community placements to be successful. Care coordination with other health professionals, support of the providers, and frequent review of care plans is essential to help these clients avoid costly institutionalized care. Low case ratios and increased skill sets need to be developed for case managers assigned to these clients.

- Provider Supports: Models need to be developed to allow very small community providers to succeed. Models should include risk management interventions, access to 24-7 nursing, training and support to increase provider skill sets, and provide business and administrative support for foster home providers.

Specific barriers will be addressed on a case-by-case basis.

Information Systems

Oregon is in the midst of implementing a new Medicaid Management Information System (MMIS), scheduled to occur during the first calendar quarter of the 2008 State Fiscal Year. Information from the existing MMIS will be converted to the new MMIS, including all participant demographic and benefit package. Oregon will identify Medicaid and MFP participation eligibility prior to transition through the MMIS; and will track services eligible for the enhanced FMAP through the new MMIS in accordance with later CMS instruction. We will use our existing CA/PS tools, coupled with utilization and outcome reports from MMIS, to monitor quality of services post transition.

Phase Three

Implementation of Phase Three

Seniors and People with Disabilities proposes that Phase 3 of its rebalancing demonstration focus on approximately 400 adults who have lived in Oregon nursing facilities for six months or longer as of January 1, 2009. Specifically, we propose to transition approximately 100 adults with developmental disabilities as evidenced by a PASRR, and an additional 300 adults who have complex medical needs which are stable and do not require daily registered nurse services. Examples of this latter population include persons with morbid obesity who require bariatric care, or persons with respiratory or neurological disorders who require tracheotomies, suctioning and/or ventilator care. Transition sites will be located in Oregon's six MSAs – Bend, Corvallis, Eugene, Medford, Portland and Salem. Phase 3 participants will transition from nursing facilities to community-based residences in which no more than 4 unrelated individuals reside, to apartments with individual leases or, in a few cases, to their own homes or to family homes. Services to be offered to Phase 3 participants with developmental disabilities will include:

Qualified Home and Community Based Program (State Plan and 1915(c) services)	**Home and Community-Based Demonstration Services**	**Supplemental Demonstration Services**
• Personal Care • In-home Support Services • Home Accessibility • Adult Day Health • Respite • Targeted Case Management • Community Residential Programs • Habilitation/Extended Habilitation • Transportation • Specialized Medical Equipment and Supplies • Family Services • Crisis/Diversion Services • Contract Registered Nursing		• Community Transition Services • Assistive Technology • Nutrition Services • Durable Medical Equipment • Housing Related Services • Service Animals • Substance Abuse Services

Services to be offered to Phase 3 participants with physical disabilities will include:

Qualified Home and Community Based Program (State Plan and 1915(c) services)	**Home and Community-Based Demonstration Services**	**Supplemental Demonstration Services**
• Personal Care • Adult Foster Care • Assisted Living • Specialized Living • Home-Delivered Meals • In-Home Services • Home Accessibility • Contract Registered Nursing • Transportation • Community Transition • Adult Day Health • Respite	• Targeted Case Management	• Assistive Technology • Nutrition Services • Durable Medical Equipment • Family Services • Housing Related Services • Substance Abuse Services

Anticipated Waivers

The services to be offered through both the Qualified Home and Community-Based Programs for people with developmental disabilities and for people with physical disabilities are currently approved services in Oregon's 1915(c) waivers. At this time, SPD anticipates that we may request a waiver of Section 1902(a)(27) to allow Phase 3 participants to exercise self-directed services to the maximum extent possible.

Increasing the dollar and percentage of expenditures for HCBS

Phase 3 participants currently reside in Oregon nursing facilities, at an average cost of more than $5,000 per month. While Phase 2 participants demonstrate regular need for nurse assessment and monitoring, they do not demonstrate the need for round the clock nurse availability that is shown by more nursing facility appropriate residents; rather, they demonstrate constant, daily need for less medical support and supervision. MFP allows SPD the opportunity to put together a package of Home and Community-Based supports that will more appropriately

meet these adults' needs at a lesser cost than nursing facility care. SPD also believes that implementation of self-direction to the maximum extent possible in the delivery of Phase 3 services will lead to better outcomes and greater participant satisfaction. Once developed, SPD plans to make the Phase 3 service package available to all individuals who meet the targeting criteria dependent on provider availability.

Benchmarks

Oregon proposes to establish benchmarks that transition at least 150 Phase 3 participants in the 2009 calendar year and at least 250 Phase 3 participants in the 2010 calendar year. Oregon proposes to reserve the right to transition Phase 3 participants more quickly if possible, but in no case will establish more than 400 individuals as Phase 3 demonstration participants.

Recruiting Participants

The department will work closely with nursing facilities, local agencies, Area Agencies on Aging, county developmental disability staff, ombudsmen, community organizations and support centers, community members and family to identify possible participants. The department will use its Client Assessment and Planning System (CA/PS) tool and the MDS to identify individuals who meet the Phase 3 targeting requirements.

The department will use person-centered approaches that will ensure that only those individuals who want to move to a community setting will be asked to participate. However, due to the significant level of impairment of some of the individuals being selected for this demonstration, its is likely that family members will also play a critical role in determining if a person would prefer to stay in the institution or move to a community setting. Specialized case managers, trained in transition related services and issues will be used to approach individuals who may be likely candidates. Case managers and assigned registered nurses will also be used

to identify possible placements, develop risk mitigation strategies, such as assessing informal supports, and to coordinate other services such as housing, transportation and access to medical services. Final transition plans will be made cooperatively with participants, family members and care providers. Nurses will review final transition plans and will be actively involved in both the transition to their new care setting as well as on-going services.

Cross agency service delivery collaboration.

Oregon's extensive network of community-based care providers was built with the active engagement of providers, industry associations, local Area Agencies on Aging, other state agencies and consumer and advocacy organizations. Phase 3 of this grant will increase the focus on development of smaller community housing models that include more nurse monitoring than is traditional in the state's community settings as well as wrap around staffing availability. We also plan to explore development of individual apartment settings in which residents share care services. SPD has a rich history of providing community housing in small neighborhood homes for persons with developmental disabilities. During the last decade, more than 200 homes were constructed or retrofitted to provide safe and appropriate homes accommodate the needs of the former residents of Fairview State Training Center, a large institution that closed in 2000. An extensive individualized planning process took into account the preferences and geographical location of the clients and their families. The development of these homes occasionally met with some neighborhood resistance, but they now are sterling examples of successfully integrating persons with disabilities into communities throughout Oregon.

The housing was developed through a partnership with Oregon Housing and Community Services Department (HCSD) and private not-for-profit housing development agencies. HCSD sold general obligation bonds to fund the homes and the non-profit agencies became the owners.

Those funds continue to provide and maintain quality community living opportunities for nearly 1,000 people who were residents of the ICFMR.

The partnership between HCSD and the Department of Human Services continues. In October 2004 the Department received a CMS Real Choice grant to integrate long term supports with affordable housing. The focus of that grant is to remove the barriers that prevent assistive technology from being more fully utilized in housing for persons with disabilities. The grant funds a full time technology specialist that is jointly housed at DHS and HCSD. Grant activities are being instrumental in modifying the housing and service delivery policies to more fully realize the potential offered by technology in housing for persons with disabilities. Stakeholders communicate through a website, technologyforhousing.org, that is funded by the grant. If awarded, the money follows the person grant will take advantage of breakthroughs in the use of technology to streamline services and community housing for persons formerly living in institutions.

SPD will work across DHS to provide effective and appropriate substance abuse services in partnership with the DHS Addictions and Mental Health Division (AMHD). We will need to build statewide and local coalitions, in collaboration with the Oregon Housing and Community Services and local housing authorities, to develop effective strategies to address housing barriers. The department will work with the Oregon Department of Transportation to address concerns around non-medical transportation. DHS will also actively partner with the Oregon Disabilities Commission, the Oregon Developmental Disabilities Commission, the People with Disabilities Advisory Council, the Oregon Association of Area Agencies for Aging and Disability, county government, the Oregon Advocacy Coalition, and other organizations and providers to develop and to help transition individuals and systems from institutionalization to community settings.

Services through the demonstration program

SPD intends that a full package of Medicaid home and community-based services remain available to Phase 3 participants following the year in which they receive services through the demonstration program. We expect that most Phase 3 participants will continue to live in community residences of 4 or fewer; however, the full package of services available through both the Comprehensive Services Waiver for People with Developmental Disabilities and through the Home and Community-Based Services Waiver for the Aged and Physically Disabled will be available to Phase 3 participants as appropriate should they choose to move to another residence. The waiver service package is included on page 9 of this application.

Quality Management Strategy

Quality Management strategies and systems will be implemented in accordance with the Quality Management Provisions of Oregon's CMS-approved 1915(c) Home and Community-Based Services Waiver for the Aged and Physically Disabled and its Home and Community-Based Comprehensive Services Waiver for People with Developmental Disabilities. Additional discussion is found on pages 20 and 21 of this application.

Barriers to flexible use of Medicaid dollars

The department uses a global long-term care budget, which allows for flexible funding among services and also allows services to be tailored to meet the individual's needs. This has allowed Oregon to develop a robust network of smaller, community residential providers for people with developmental or physical disabilities. Community providers are generally required to provide comprehensive supports to their residents. However, people transitioning from facilities to the community, especially to smaller settings, often face specific barriers that have not been met by Medicaid. Lack of routine rebasing, coupled with perennial budget shortfalls,

have led to service rates that are not commensurate with the level of care that is required. SPD intends to use the pre-implementation stage to assess provider capacity and determine what issues must be addressed for the identified populations prior to Phase 3 implementation. Issues that are already identified include:

- Case Management and monitoring: High need clients require more than annual service assessments and crisis management in order for community placements to be successful. Care coordination with other health professionals, support of the providers, and frequent review of care plans is essential to help these clients avoid costly institutionalized care. Low case ratios and increased skill sets need to be developed for case managers assigned to these clients.

- Provider Supports: Models need to be developed to allow very small community providers to succeed. Models should include risk management interventions, access to 24-7 nursing, training and support to increase provider skill sets, and provide business and administrative support for foster home providers.

There are also specific barriers that could be addressed on a case-by-case basis. For example, individuals moving to private homes or apartments have often been unable to access Medicaid funds for housing deposits, first and last months' rents, assistive technology and purchase of a service animal. For those moving to community residential programs, the provider often does not have the equipment or training they need to address the exceptional needs of those that the state has identified for this grant such as bariatric equipment, home modifications like sprinkler systems and back-up generators, and specialized training. The department will use the 9 months during the pre-implementation phase to design criteria for these specialized services and to create the systems to pay for those that are approved.

An additional barrier impacting all community based care residents is the lack of substance abuse services, especially funded through Medicaid. The department will work internally with Addictions and Mental Health Division (a sister division) to develop assistance for Phase 3 participants transitioning to the community who would benefit from these services.

Information Systems

Oregon is in the midst of implementing a new Medicaid Management Information System (MMIS), scheduled to occur during the first calendar quarter of the 2008 State Fiscal Year. Information from the existing MMIS will be converted to the new MMIS, including all participant demographic and benefit package. Oregon will identify Medicaid and MFP participation eligibility prior to transition through the MMIS; and will track services eligible for the enhanced FMAP through the new MMIS in accordance with later CMS instruction. We will use our existing CA/PS tools, coupled with utilization and outcome reports from MMIS, to monitor quality of services post transition.

Phase 4

Implementation of Phase Four

Seniors and People with Disabilities proposes that Phase 4 of its rebalancing demonstration focus on up to 40 adults with developmental disabilities who have lived in Oregon's only remaining Intermediate Care Facility for persons with Mental Retardation (ICFMR) for six months or longer as of January 1, 2009. Transition sites will be located throughout Oregon, but primarily found in the 42 Oregon cities that have a population of 10,000 or more. Individuals will be transitioned from the ICFMR to community-based residences in which no more than 4 unrelated individuals reside.

Services to be offered will include:

Qualified Home and Community Based Program (State Plan and 1915(c) services)	**Home and Community-Based Demonstration Services**	**Supplemental Demonstration Services**
• Respite Care • Habilitation: day habilitation including employment and community inclusion, prevocational services, supported employment, adult and foster care, adult group homes, supported living services • Environmental accessibility adaptations • Transportation • Specialized medical equipment and supplies • Family Training • In home support services • Crisis/diversion services • Targeted Case Management • Personal Care		• Assistive Technology • Nutrition Services • Durable Medical Equipment • Housing Related Services • Service Animals • Transportation • Substance Abuse Services

Anticipated Waivers

The services to be offered through the Qualified Home and Community-Based Program are currently approved services in Oregon's 1915(c) waiver for Comprehensive Services for individuals with Developmental Disabilities. At this time, SPD anticipates that no additional waivers will be necessary to transition Phase 4 participants.

Increasing the dollar and percentage of expenditures for HCBS

The client census of Oregon's only remaining ICFMR has gradually declined over a period of years. As the number of individuals served has gone down to 40 or fewer, the per-person rate necessary to sustain the ICFMR infrastructure has increased to approximately $25,000 per month. Most important, from a programmatic standpoint, the individuals currently residing at the ICFMR can be served in a manner that is better tailored to individual needs and preferences in community-based settings under the Developmental Disabilities Comprehensive Services Waiver if comparable supports are made available through rebalancing. People currently in the ICFMR have similar needs to many people now living successfully in small community homes.

MFP allows SPD the opportunity to put together a package of Home and Community-Based supports that will more appropriately meet these individual's needs in a less restrictive setting at a lesser cost than ICFMR facility care. .

Benchmarks

Oregon proposes to establish benchmarks that transition up to 40 Phase 4 participants in the 2009 calendar year. Oregon proposes to reserve the right to transition Phase 4 participants more quickly if possible, but in no case will establish more than 40 individuals as Phase 4 demonstration participants.

Identifying Participants

Eligible individuals will be those who have been enrolled for more than six months in Oregon's ICFMR program. The department will use person-centered approaches that will include individuals and their guardians, family members and Individual Service Plan teams in transition planning. Case managers and Regional Coordinators will be used to identify possible placements, develop risk mitigation strategies, such as assessing informal supports, and to coordinate other services such as housing, transportation and access to medical services. Final transition plans will be made cooperatively with participants, family members and care providers.

Cross agency service delivery collaboration.

Oregon's extensive network of developmental disabilities community-based care providers was built with the active engagement of providers, industry associations, other state agencies and consumer and advocacy organizations. Phase 4 of this grant will increase the focus on increased development of smaller community housing models. DHS will need to build statewide and local coalitions, in collaboration with the Oregon Housing and Community Services and local housing authorities, to develop effective strategies to address housing barriers. The department will work with the Oregon Department of Transportation to address concerns around non-medical transportation. DHS will also actively partner with the Oregon Council on Developmental Disabilities, the Oregon Developmental Disabilities Coalition, the Oregon Rehabilitation Association, the Community Providers Association of Oregon, and other organizations and providers to develop and to help transition individuals and systems from institutionalization to community settings.

Services after the demonstration program

SPD intends that a full package of Medicaid home and community-based services remain available to Phase 4 participants following the year in which they receive services through the demonstration program. We expect that most Phase 4 participants will continue to live in community residences of 4 or fewer, however, the full package of services available through the Home and Community-Based Comprehensive Services Waiver for persons with Developmental Disabilities will be available to Phase 4 participants should they choose to move to another residence. The waiver service package is included on page 9 of this application.

Quality Management Strategy

Quality Management strategies and systems will be implemented in accordance with the Quality Management Provisions of Oregon's CMS-approved 1915(c) Home and Community-Based Comprehensive Services Waiver for People with Developmental Disabilities. Additional discussion is found on pages 20 and 21 of this application.

Barriers to flexible use of Medicaid dollars

The department uses a global comprehensive services budget, which allows for flexible funding among services and also allows services to be tailored to meet the individual's needs. This has allowed Oregon to develop an extensive system for serving individuals with developmental disabilities. Participants in this project may have access, depending upon their individual needs, to supported living, adult foster homes, or group homes with up to four residents. However, people transitioning from facilities to the community, especially to smaller settings, often face specific barriers, including availability of suitable housing, qualified staffing, and professional services. SPD intends to use the pre-implementation stage to assess system capacity and determine if special initiatives are needed to provide critical services.

Information Systems

Oregon is in the midst of implementing a new Medicaid Management Information System (MMIS), scheduled to occur during the first calendar quarter of the 2008 State Fiscal Year. Information from the existing MMIS will be converted to the new MMIS, including all participant demographics and benefit packages. Oregon will identify Medicaid and MFP participation eligibility prior to transition through the MMIS; and will track services eligible for the enhanced FMAP through the new MMIS in accordance with later CMS instruction. We will use our existing Quality Management tools, coupled with utilization and outcome reports from MMIS, to monitor quality of services post transition.

Part 3 – Preliminary Budget and Organizational Staffing Plan

Organizational Structure

The Oregon Department of Human Services is the state's health and human services agency. Established in 1971 as the Department of Human Resources, it changed to its current name in 1999. DHS is the largest department in Oregon state government, employing approximately 9,500 people and operating with a budget of $9.9 billion during 2005-07. The Department's mission is "helping people to become independent, healthy and safe." DHS strategies aimed at accomplishing these goals include self-sufficiency, protection, health, independence and prevention. Five program divisions deliver services. **Children, Adults and Families Division** is responsible for administering self-sufficiency and child-protective programs. The **Addictions and Mental Health Division** administers mental health and substance abuse services, and operates Oregon State Hospital and the Blue Mountain Recovery Center. The **Public Health Division** provides public health services and also maintains the state's vital records. The **Division of Medical Assistance Programs** administers low-income medical programs. The **Seniors and People with Disabilities Division (SPD)** is responsible for the administration of programs that increase the independence of, and help protect, seniors and people with disabilities. Its functions include abuse investigation, licensing of nursing facilities, help in arranging and paying for Medicaid long-term care services, Oregon Project Independence, and Lifespan Respite. Many of the services are provided to clients through local Area Agency on Aging (AAA) offices. SPD also handles in-home, group-home and crisis services for people with developmental disabilities. Another SPD function is eligibility determination for federal

Social Security Disability benefits. Current high-level DHS and SPD organizational charts are found in Appendix 1 to this application.

Staffing Plan

Initial MFP staffing will bring on board staff needed for the pre-implementation phase, including a full-time project director, quality assurance and analysis staff, and administrative support. These staff, with others in the department, will finalize the demonstration design and identify operational changes that will be needed to successfully administer the transition. They will review and modify tools for screening and assessing people who are candidates for transitioning to the community and will develop protocols for working with the targeted individuals and their families. Project staff, in conjunction with members of the SPD management team, will establish processes for fully engaging stakeholders in the planning efforts and in ongoing implementation. Pre-implementation staff will include:

1 full-time Project Director – anticipated start date February 2007
1 full-time Research Analyst – anticipated start date March 2007
1 full-time QA coordinator - anticipated start date March 2007
1 full-time Business Analyst – anticipated start date March 2007
1 full-time administrative support – anticipated start date March 2007

At this time, SPD anticipates additional project staffing being brought on by phases.

Phase 1 staffing will require the addition of one full-time Children's Services Coordinator. Implementation of **Phase 2** will require the addition of 6 full-time teams made up of a nurse and a case manager specializing in transition related issues to work with the population of seniors moving to the community. Staff will be phased in and will be on board at least three months before the start of each year of Phase 2.

Phase 3 encompasses two distinct populations – adults with physical disabilities and adults with developmental disabilities. Staffing for the population with physical disabilities will employ the same model described above of teams of nurses and specialized case managers. The 300 adults with physical disabilities envisioned in this proposal require 6 additional teams to be staffed. Staffing for the population of 100 individuals with developmental disabilities to be moved will require addition of 2 full-time program coordinators with specialized knowledge of developmental disabilities to provide coordinate and monitor all phase 3 work.

SPD believes that no additional staff will be needed to accomplish **Phase 4**.

In addition, SPD plans to devote substantial amounts of existing staff time as in-kind grant support. A preliminary list of management staff involved include:

Name	**Position**	**Role and Responsibilities**	**Percentage of Time (Over life of project)**
Jeanette Burket	Administrator, Office of Senior and Disability Services	Direction and guidance, Phases 2 and 3	10
Bob Clabby	Superintendent, Eastern Oregon Training Center	Oversight responsibilities, Phase 4 implementation and on-going	50
Cathy Cooper	Deputy Assistant Director	Overall direction and guidance	5
Joe Easton	Manager, In-Home Services	Oversight responsibilities, Phases 2 and 3 implementation and on-going	12
Mary Lee Fay	Administrator, Office of Developmental Disability Services	Direction and guidance, Phases 1, 3 and 4	10

Deanna Hartwig	Administrator, Office of Federal Reporting and Financial Eligibility	Federal compliance responsibilities, all phases	10
Megan Hornby	Manager, Community Based Care Licensing and Health	Oversight responsibilities, Phases 2 and 3 implementation and on-going	12
Julia Huddleston	Manager, Planning, Research and Rate Setting	Oversight of analysis and financial model development; all phases	15
Tina Kitchin, M.D.	Medical Director	Consulting	5
Mike Maley	Manager, Community and In-Home Services	Oversight responsibilities, Phase 3 implementation and on-going	10
James Toews	DHS Assistant Director	Overall direction and guidance	5
Janette Williams	Manager, Childrens Services	Oversight responsibilities, Phase 1 implementation and on-going	15
Jane Ellen Weidanz	Manager, Intergovernmental Relations	Inter-governmental and inter-agency liaison all phases	10

Position descriptions for staff dedicated to the project are located in Attachment 3 as are resumes for key SPD staff members.

Budget Narrative

Medicaid administrative directly associated with the demonstration project are assumed to be reimbursable according to the requirements of 42 CFR 433.15.

SPD's budget assumes the following milestones:

2007 Federal Fiscal Year:
All dedicated project staff are hired
Phase 1 project staff is hired (7/2007)

2008 Federal Fiscal Year:
Phase 1 demonstration begins October 1, 2007. 31 participants will transition in FFY 2008.
Phase 2 project staff hires begin (2 teams) (10/2007)
Phase 2 begins January 1, 2008. 61 participants will transition by year-end FFY 2008.
Phase 3 project staff begins (2 teams physical disabilities; 2 staff developmental disabilities) (7/2008)
Additional Phase 2 staff hired (2 teams) (7/2008)

2009 Federal Fiscal Year:
Phase 1 transition continues through December 31, 2008. 9 additional children transition.
Phase 2 continues. 94 additional participants transition in the 2009 FFY.
Phase 3 begins January 1, 2009. 110 participants will transition in the 2009 FFY.
Additional Phase 2 staff hired (2 teams) (7/2009)
Additional Phase 3 staff hired (4 teams) (7/2009)
Phase 4 begins January 1, 2009. 14 participants will transition in the 2009 FFY.

2010 Federal Fiscal Year:
Phase 2 continues. 145 additional participants will transition.
Phase 3 continues. 290 additional participants will transition.
Phase 4 continues. 26 additional participants will transition.

2011 Federal Fiscal Year:
Project phases 2, 3 and 4 completed not later than 9/30/2011.

Money Follows the Person Demonstration Grant Budget Estimate Presentation Demonstration Funding Request					
Federal Fiscal Year	Qualified HCBS Program Services (demonstration share at enhanced FMAP of 80.45%)	Demonstration HCBS services (demonstration share at enhanced FMAP) of 80.45%	Supplemental Demonstration Service Costs (demonstration share at regular FMAP) of 60.89%	Administrative Costs and Evaluation Costs (at 50% admin FMAP rate)	**Total FY Estimated Funding Request**
2007	$0	$0	$0	$86,001	$86,001
2008	$2,498,240	$15,944	$289,471	$440,754	$3,244,409
2009	$13,256,701	$61,328	$1,117,332	$846,160	$15,281,521
2010	$34,057,508	$10,312	$2,464,979	$1,262,101	$37,794,900
2011	$45,244,673	$189,798	$1,761,395	$1,251,670	$48,447,536
TOTAL	$95,057,121	$277,383	$5,633,177	$3,886,685	**$104,854,366**

The following assumptions have been made in pricing project phases:

	Phase 1	**Phase 2**	**Phase 3**	**Phase 4**
Eligible Individuals	40	300	400	40
First transition date	10/1/2007	1/1/2008	1/1/2009	1/1/2009
Last transition date	12/2008	09/2010	09/2010	09/2010
Schedule	2 or 3 children per month	6 per month 2008; 7 – 8 per month 2009; 9 – 15 per month 2010	12 – 14 per month 2009; 15-30 per month 2010	1 or 2 per month 2009; 2 or 3 per month 2010
Maximum rate to be paid for Qualified HCB Program	$7,500 per month	$4,500 per month	$6,000 per month	$10,086 per month
Maximum rate to be paid for HCB demonstration services	$100 per month	-0-	$100 per month	$246 per month
Maximum rate to be paid for Supplemental Demonstration Services	$1,000 per month	$1,000 per month	$1,000 per month	$750 per month
Assumed cost increases	5% annually	5% annually	5% annually	5% annually

Part 4 – Assurances

Informed Consent

Oregon assures that it will comply with all requirements of 45 CFR 46.116 in the process of obtaining informed consent for participants or their authorized representatives, and with all requirements of 45 CFR 46.117 in documentation of that consent. Information about the demonstration project will be presented to enable participants or their representatives to voluntarily decide whether or not to participate as a research subject.

Choice of Community-Based Residence

Oregon assures that an individual who is eligible for services under the demonstration project, or his or her legal representative, will be informed, during the assessment and eligibility process, of feasible alternatives for long-term care and given a choice as to which type of community-based service to receive. Project staff will document the offer of choice on the MFP demonstration election form. The offer of choice will be given before the individual enters the demonstration project. The individual's, or his or her legal representative's, signature is obtained when possible. If it is not possible to obtain the individual's, or his or her legal representative's, signature on the form, confirmation of the choice can be documented in the following manner: witnessed mark of the individual or his or her legal representative; a letter from the legal representative indicating choice and acknowledgment of fair hearing opportunity; witnessed and documented phone conversation with the individual or his or her legal representative regarding choice and fair hearing opportunity.

Public process

The genesis of Oregon's MFP application can be found in the Governor Ted Kulongoski's 2005 budget message. Governor Kulongoski directed the Department of Human Services to

begin a long-range planning process to address the future of Oregon's long-term care system. "Of paramount concern is Oregon's ability to provide compassionate and effective care to its expanding elderly population, while recognizing that such growth must be sustainable within projected revenues," said the Governor.

Beginning in August 2005, the Department of Human Services (DHS) convened a Workgroup on the Future of Long-Term Care in Oregon. The workgroup included representatives of consumers, advocates, the long-term-care industries, acute care providers and state agencies. Seven smaller task groups examined questions around research and data, healthy aging, planning for long-term care needs, elder-friendly communities, pre-Medicaid safety net services, Medicaid long-term care services and integrated care models. Preliminary workgroup recommendations were presented to more than 500 Oregonians in a series of community forums throughout the state, sponsored by the Governor's Commission on Senior Services. Task group activities will continue with a goal of further development and refinement of recommendations. Members of the Workgroup, along with representatives of other interested organizations, were invited to participate in a meeting that SPD held on October 25 to discuss its intent to apply for the MFP grant. Grant timelines, with short required turnaround, precluded the time necessary to encompass thoughtful input from stakeholders. SPD intends, that if awarded a Money Follows the Person grant, advocate, staff and industry representatives will be at the planning table as full participants.

Maintenance of Effort

Oregon assures that the total expenditures under the State Medicaid program for home and community-based long-term care services will not be less for any fiscal year during the Money Follows the Person demonstration project than for the greater of such expenditures for fiscal year

2005. SPD assures that it will provide information as required by the CMS to monitor this assurance. SPD intends that all MFP demonstration participants will be entitled to the full range of home and community-based services under the appropriate 1915(c) waiver after their MFP transition ends. SPD further intends to continue to offer the "qualified Home and Community-Based Program services" under the MFP to 1915(c) waiver participants at the end of each phase of the MFP demonstration, dependent on provider availability. Required Maintenance of Effort forms and narrative are found in Part 3 of this application.

Reporting

Oregon assures that it will compile and transmit reports as required by CMS that will permit reliable comparisons of MFP projects across states. SPD further assures that an effective evaluation of the MFP demonstration will be submitted timely and will adhere to the specifications established by CMS.