Transmittal #13-09
OMB No.: 0938-1024

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: __OREGON_____

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation(s)

3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy

1915(j) X_ Self-Directed Personal Assistance Services, as described and limited in Supplement _3__ to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

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1915(j) Self-Directed Personal Assistance Services

Amount, Duration, and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

_X_ Self-Directed Personal Assistance Services, as described in Supplement _3_ to Attachment 3.1-A.

_X_ Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

____ No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.

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Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

A. _____In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 24 of the Medicaid State Plan.

B. __X_ In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver. ***Aging and Physically Disabled 1915(c) waiver #OR.0185.R05.01.**

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. _X___ State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

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B. _____ Services included in the following Section 1915(c) Home and Community-Based Services waiver(s) to be self-directed by individuals eligible under the waiver(s). Please list waiver names and services to be included.

iii. Payment Methodology

A. __X__ The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based wavier services.

B. _____ The State will use a different payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached.

iv. Use of Cash

A. __X__ The State elects to disburse cash prospectively to participants' self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. _____ The State elects not to disburse cash prospectively to participants' self-directing personal assistance services.

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v. Voluntary Disenrollment

Please describe the safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional personal assistance services.

Participants may voluntarily disenroll from the IC program by communicating with their case manager. Individuals who voluntarily disenroll will have other service alternatives available to them, such as those services covered under the State plan. A voluntary disenrollment will not cause a reduction in participant's benefits that were determined based on their assessments and service plans. The case manager will be responsible for disenrolling the participant and will assist the participant in selecting other services and programs to serve their needs.

vi. Involuntary Disenrollment

A. Please specify the circumstance under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to traditional services.

Involuntary disenrollment will occur when a participant proves to be unable to self-direct purchase and payment of long-term support services, when a surrogate proves incapable of acting in the best interest of the participant, or when persons invalidate the terms of their Participation Agreement. They may be reinstated into another long-term supports option of their choice. Involuntary disenrollment may result from any of the following:

- A provider claim of non-payment of wages where the consumer or his/her representative cannot show proof of payment.
- Evidence that the Medicaid cash benefit was used for illegal purposes in accordance with local, state or federal statutes.
- Evidence that the Medicaid cash benefit cash benefit was used for purposes other than those that meet the individual's care needs.

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- Failure to comply with legal/financial obligations as an employer of domestic workers and/or unwillingness to participate in counseling and training to remedy lack of compliance.
- Inability to manage the cash benefit as evidenced by:
  - Overdrafts of the consumer's Independent Choices bank account;
  - Non-compliance with recommendations for training or use of community resources; or
- Failure to maintain health and well-being by obtaining adequate personal care as evidenced by:
  - Declines in physical functional status which are not attributable to changes in health status; or
  - Substantiated complaints of the consumer's self-neglect, neglect, or other abuse on the part of the consumer or surrogate.

B. The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-direction and traditional service delivery models.

Disenrollment, for reasons other than Medicaid ineligibility, will not cause a reduction in participant's benefits that were determined based on their assessments and service plans. The case manager will be responsible for disenrolling the participant and will assist the participant in finding other programs that may better serve their needs through the State plan. The case manager will assist the participant in rectifying any of the problems listed in "A" above before taking steps to disneroll the participant from the program.

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If the issues cannot be rectified, the case manager will issue to participants a formal notice prior to any action taken to disenroll them from the program, whether they opt to transition into State plan attendant care services or not. The notice will include information about the participant's rights to an administrative hearing if they disagree with the action and the right to continuing benefits under the 1915(j) until a final order is issued.

vii. Participant Living Arrangement

Please list any additional restrictions on participant living arrangements, other than homes or property owned, operated or controlled by a provider of services, not related by blood or marriage to the participant.

Consumers must demonstrate the ability to assess and plan for care by maintaining a stable living situation, defined as continuous tenancy at a given residence for the past three months. If health issues or a no-fault situation has prompted a move within the past three months, proof of any three consecutive months of tenancy during the past year is acceptable.

In the event a participant moves from their own home to a substitute home such as an assisted living facility, an adult foster home, a residential care facility or into a nursing home, he or she will be considered ineligible for the IC Program, disenrolled and transitioned to another program that may better meet his or her care needs.

The provider of services may be related by blood or marriage.

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viii. Geographic Limitations and Comparability

A. __X__ The State elects to provide self-directed personal assistance services on a statewide basis.

B. _____ The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:_____

C. _____ The State elects to provide self-directed personal assistance services to all eligible populations.

D. __X__ The State elects to provide self-directed personal assistance services to targeted populations. Please describe: Aged individuals and physically disabled individuals 18 years and older that are enrolled in the APD 1915(c) waiver (0185) for Aged and Physically Disabled individuals over 18 that meet nursing facility level of care.

E. __X__ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

F. _____ The State elects to provide self-directed personal assistance services to _____ (insert number of) participants, at any given time.

ix. Assurances

A. The State assures that there are traditional personal assistance services, comparable in amount, duration and scope, to self-directed personal assistance services.

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B. The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services.

C. The State assures that an evaluation will be performed of participants' need for self-directed personal assistance services for individuals who meet the following requirements:
   i. Are entitled to medical assistance for personal care services under the Medicaid State Plan; or
   ii. Are entitled to and are receiving home and community-based services under a Section 1915(c) waiver; or
   iii. May require self-directed personal assistance services; or
   iv. May be eligible for self-directed personal assistance services.

D. The State assures that individuals are informed of all options for receiving self-directed and/or traditional State Plan personal care services or personal assistance services provided under a Section 1915(c) waiver, including information about self-direction opportunities that is sufficient to inform decision-making about the election of self-direction and provided on a timely basis to individuals or their representatives.

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E. The State assures that a support system will be provided to individuals that meets the following:
   i. Appropriately assesses and counsels individuals prior to enrollment;
   ii. Provides appropriate counseling, information, training and assistance to ensure that participants are able to manage their services and budgets;
   iii. Offers additional counseling, information, training or assistance, including financial management services:
      1. At the request of the participant for any reason; or
      2. When the State has determined the participant is not effectively managing their services identified in their service plans or budgets.

F. The State assures that an annual report will be provided to CMS on the number of individuals served through this State Plan Option and total expenditures on their behalf, in the aggregate.

G. The State assures that an evaluation will be provided to CMS every three years, describing the overall impact of this State Plan Option on the health and welfare of participating individuals, compared to individuals not self-directing their personal assistance services.

H. The State assures that the provisions of Section 1902(a)(27) of the Social Security Act, and 42 CFR 431.107, governing provider agreements, are met. The State provides Criminal History Checks at no cost to participants for all providers. However, the participant maintains the ability to decide whether or not to employ the provider. As a program truly governed by self-direction, Independent Choices allows the participant to recruit, hire, train, and fire the provider of their choice.

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I. The State assures that a service plan and service budget will be developed for each individual receiving self-directed PAS. These are developed based on the assessment of needs.

J. The State assures that the methodology used to establish service budgets will meet the following criteria:
   i. Objective and evidence based.
   ii. Applied consistently to participants.
   iii. Open for public inspection.
   iv. Includes a calculation of the expected cost of the self-directed PAS and supports if those services and supports were not self-directed.
   v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.
   vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.
   vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant's needs.

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viii. Includes a method of notifying participants of the amount of any limit that applies to a participant's self-directed PAS and supports.

ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

x. Service Plan

Please describe safeguards in place, when States permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

Entities or individuals that have responsibility to develop service plans do not provide other direct services to participants.

xi. Quality Assurance and Improvement Plan

Please describe the State's quality assurance and improvement plan, including

i. How it will conduct activities of discovery, remediation and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and

ii. The system performance measures, outcome measures and satisfaction measures that the State will monitor and evaluate.

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Anyone may file a complaint with the Governor's Advocacy Office (GAO) in the Office of the Director of the Department of Human Services or with the local APD or AAA office. Local APD and AAA offices have the responsibility to resolve any complaints that are brought to them. In the event that the GAO receives the complaint they will enter it in a database and forward the complaint to the appropriate branch office or responsible program entity to initiate the resolution process. APD central office can access monthly reports on the types of complaints filed, the outcomes and whom the complaint involves.
There is no limitation on the types of complaints an individual may file. The majority of complaints are regarding client benefits or dissatisfaction with the case manager. The goal is to remedy complaints at the lowest level possible. After the local office receives a complaint from the consumer directly or via the GAO the remediation process begins. The process includes:

- Participant contacted by local program supervisor within a mandated time frame, at which time an in-person or telephone meeting is scheduled (participant may have a formal or informal support person/advocate present during the meetings);
- Fact finding and research is conducted by the local office prior to participant contact, during the meeting session, and following the meeting using a variety of sources and methods;
- Once the complaint is resolved satisfactorily, a letter of determination is sent to the participant (optional on a case-by-case basis), and the GAO and next-level manager are notified;
- If the complaint is not resolved, it is referred to next management level for review and follow-up.

If the complaint cannot be resolved at the local office and service area levels, a Central Office team will assume reexamination and continuance of complaint process.

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The participant may pursue grievance through the GAO or the appropriate federal program authority, including the court system.

The DHS CMS Waiver Review Unit reviews and monitors the accuracy and consistency of waiver operational and administrative functions performed by all local offices, including AAAs, through two ongoing processes:

a. In a two-year cycle, the CMS Waiver Review Unit conducts a field review, evaluating activities in all local DHS and AAA offices against State plan requirements such as timeliness, accuracy, appropriateness of services, services billed are actually received, compliance with State and Federal regulation, program outcomes, consumer satisfaction and cost effectiveness. The process of evaluation involves CMS Waiver Review Unit examination of a sample of participant cases through review of data stored in electronic databases, review of case files on-site, and individual interviews that include an assessment of consumer satisfaction. The CMS Waiver Review Unit records findings using a standardized tool and issues a formal finding in a report to the local office identifying trends in policy and rule application. The local office must submit a plan of correction to DHS within 30 days of receipt of this report that addresses any issues found in the CMS Waiver Review Unit report. DHS then issues a final report to the local office. DHS enters details of the review of each individual's record into the Quality Management Data Base (QMDB) for tracking. The CMS Waiver Review Unit revisits local offices to follow-up with the written corrective action plans to ensure compliance and remediation of any issues addressed in the final report.

The assessment methods used by the CMS Waiver Review Unit include file reviews, on-site reviews, interviews and assessments with individuals receiving services, and service plan reviews. Data is entered into a database.

1. These processes are a source of ongoing data about assistance with waiver enrollment, LOC activities, participant services plans, and prior authorization of waiver services.

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The process also provides information, through direct observation and review of factors associated with participant outcomes and satisfaction that aids evaluation of other functions such as dissemination of information concerning the waiver to potential enrollees, recruitment of providers, conduct of utilization management functions and training/technical assistance.
System performance indicators will be used to measure and track program activities and processes to assure that participant access, choice and satisfaction are achieved. Participant-centered outcome and satisfaction measures will be used to assure that service delivery meets the needs of the participant as determined in the Service Plan and are timely, efficient and effective, as directed by the participant.

The following performance and outcome measures will be used:

1. Participant enrollment processes are timely and accurate.
2. Participant-directed In-Home Services begin in a timely manner.
3. Overall costs for participant-directed services are comparable to or less than total costs for State plan HCBS clients living in their own homes.
4. Participants are given a choice of participant-directed or State plan HCBS services.
5. Participants have positive experiences with their care arrangements and service delivery.
6. The number of voluntary and involuntary program disenrollments is low.
7. The participant is able to address and reduce any unmet needs, with Case Manager assistance, if necessary.
8. Support for participants in delaying or avoiding admissions to nursing facilities is enhanced.
9. The Home Care Worker Registry can be utilized to support participant-directed service provisions.
10. Home Care Workers are subject to criminal history checks.
11. Home Care Workers provide services as agreed upon with and scheduled by the participant.

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12. Participants pay Home Care Workers accurately and in a timely manner.
13. Case Managers provide accurate and timely responses to participants to address their needs.
14. The proportion of abuse, neglect, misappropriation and exploitation, and protective services reports is low.
15. The Service Plans of participants have a health and safety risk assessment and strategies/protocols to address identified risks.

APD will continuously monitor the health and welfare of all participants receiving services through this option. One of the central activities to the whole APD service delivery system is the well-developed and consistent case management structure. Case managers assess for service needs, develop care plans, and authorize services. The assessment process includes a discussion and documentation of the participant's strengths, limitations and preferences.

APD will ensure that individuals receiving 1915(j) services are safe and secure in their homes, taking into account their informed and expressed choices by continuing to conduct on-site, random sample reviews by the CMS Waiver Review Unit at each APD and AAA office every two years. The review includes a home visit with the participant to verify the information from the participant's file.

APD has a variety of ongoing QA improvements to further ensure the health and welfare of participants. These projects include:

- An APD consumer satisfaction survey, conducted every 2 years, to assess satisfaction in self-directed services; beginning January 2008; and
- Distribution of an emergency preparedness handbook to all in-home service participants.

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APD maintains, and participates in, systems and procedures that promote financial accountability in all home and community-based services by conducting the following activities:

- Internal audits of various APD programs, including all in-home programs, by the DHS Internal Audit staff;
- External periodic audit activities by Oregon's Secretary of State staff.

xii. Risk Management

A. Please describe the risk assessment methods used to identify potential risks to participants.

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

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Vulnerability for Abuse. During the assessment, the case manager may identify other risks and will assess the individual's ability to make an informed decision. In those instances where the individual has the ability to make informed choices, the case manager will discuss alternatives which may mitigate the risk, may offer community resources and will document the individual's ability to make an informed decision. Individuals who demonstrate the lack of ability to understand the consequences of their decisions may be referred for protective services or guardianship services in the absence of legal representatives to assist with decision-making. Although not mandated, the State may request that a representative be selected in cases where the participant lacks the ability to make an informed decision. The participants have the right to choose their own representative. If the participant appears to be significant risk, the case manager may refer the case for protective services or guardianship service in the absence of legal representatives to assist with decision-making.

B. Please describe the tools or instruments used to mitigate identified risks.

During initial person-centered plan development and subsequent reviews, the individual's case manager conducts an assessment using the CA/PS tool to review risk factors for health and protective services with the individual, to offer resources to the individual and to plan appropriate safeguards. (Relevant portion of CA/PS assessment available on request.) During the service planning process, the individual and/or their representatives discuss risk factors and back- up plans. The individual's plan of care is developed and information regarding risk and back-up plans is incorporated into the person-centered plan. There is a section in the CAPS tool that incorporates identified risks and back-up plans. This information is part of the assessment summary section of the service plan.

Case managers use a risk assessment and monitoring instrument, in conjunction with face-to-face CA/PS evaluations, to evaluate new participants and participants who have just experienced significant changes.

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The instrument will provide guidelines for contact frequency that are commensurate with the risk assessed.
The instrument will rank the level of risk on a 0-3 scale across ten client factors, with 0 being no risk, 1 = low risk, 2 = moderate risk, and 3 = high risk.
Client factors measured:
1) Physical functioning;
2) Mental and emotional functioning;
3) Cognitive functioning;
4) Behavioral issues;
5) Income/financial issues;
6) Safety/cleanliness of residence;
7) Service plan meets medical or physical needs;
8) Service plan meets mental, emotional, or behavioral needs;
9) Adequacy or availability of informal supports;
10) Access to needed care or services;
11) Power Outage
12) Natural Disaster/Extreme Weather

Case manager client contact frequency criteria:
- For clients assessed at high risk (level 3) in three or more factor areas, at least monthly.
- For clients assessed at high risk (level 3) in one or two factor areas, at least quarterly.
- For clients assessed at moderate, low, or no risk (levels 2, 1, or 0) in all factor areas, case managers would have discretion to determine the contact frequency, with at least one additional contact per year.

If the case manager identifies risks to a recipient living at home or in a foster home, he or she may refer a Registered Nurse under contract with DHS to conduct a nursing assessment and may authorize follow-up visits. If appropriate, the RN develops a registered nurse plan of care for the participant and provider to follow, may delegate nursing tasks to the provider, and establish a monitoring schedule.

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Nursing delegation consists of training and observing that the provider is able to perform the task. The registered nurse must continue to monitor the performance of these delegated tasks and such monitoring must conform to Oregon Board of Nursing Standards. The goals of community nursing care are to: maintain participants at functional level of wellness; minimize risk for participant; maximize the strengths of the participant and the care provider; and promote autonomy and self-management of health care through teaching and monitoring. For recipients living in community-based care facilities, the case manager will work with the facility staff and the facility nurse to address health concerns. The case manager may identify other risks and will assess the individual's ability to make an informed decision. In those instances where the individual has the ability to make informed choices, the case manager will discuss alternatives which may mitigate the risk, may offer community resources and will document the individual's ability to make an informed decision. Individuals who demonstrate the lack of ability to understand the consequences of their decisions may be referred for protective services or guardianship services in the absence of legal representatives to assist with decision-making. Although not mandated, the State may request that a representative be selected in cases where the participant lacks the ability to make an informed decision. The participants have the right to choose their own representative. If the participant appears to be significant risk, the case manager may refer the case for protective services or guardianship service in the absence of legal representatives to assist with decision-making.

C. Please describe how the State will ensure that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated.

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Program participants will be assessed at program implementation and semi-annually thereafter. The assessment process will identify the consumer's ability to perform activities of daily living, self-management tasks, and determine the consumer's ability to address health and safety concerns. The case manager will conduct this assessment in accordance with standards of practice established by the Department as described in OAR Chapter 411, Division 030.

During initial plan of care development and subsequent reviews, the individual's case manager conducts an assessment using the CA/PS tool to review risk factors for health and protective services with the individual, to offer resources to the individual and to plan appropriate safeguards. (Relevant portion of CA/PS assessment available on request.)

The case manager may identify other risks associated with vulnerability to abuse and will assess the individual's ability to make an informed decision. In those instances where the individual has the ability to make informed choices, the case manager will discuss alternatives which may mitigate the risk, may offer community resources and will document the individual's ability to make an informed decision. Program participants must demonstrate and have recognized capability to appropriately direct and purchase his/her own in-home care. If the participant is unable to do so, they must have a family member, legal representative or other representative designated as surrogate who is willing and able to arrange and purchase supports on the consumer's behalf and to sign the Independent Choices Participation Agreement.

APD has alternate service providers such as Medicaid contracted in-home care agencies in some regions that an individual can employ on short notice if they cannot locate a Homecare Worker who meets their needs.

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D. Please describe how the State will ensure that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance.

Local APD and AAA case managers have the responsibility for assessing the individual's level of care and developing a plan of care in accordance with the individual's choice of services to be provided. The case manager must address all of the met or unmet needs of the participant through the assessment and provide the participant with a copy of the service plan for signature by all parties for the authorized services. The case manager will consult with the participant every six months to reassess, review and verify the appropriate services are being offered and performed. All plans are developed with input from the participant, participant's representative and anyone else the participant requests.

xiii. Qualifications of Providers of Personal Assistance

A. __X__ The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

B. _____ The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

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xiv. Use of a Representative

A. __X__ The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

i. _____ The State elects to include, as a type of representative, a State-mandated representative. Please indicate the criteria to be applied.

B. _____ The State elects not to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

xv. Permissible Purchases

A. __X__ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or decrease a participant's dependence on human assistance.

B. _____ The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or decrease a participant's dependence on human assistance.

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State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Financial Management Services

A. _____ The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

i. ___ The State elects to provide financial management services directly, or use a reporting or subagent through its fiscal intermediary in accordance with Section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or

ii. ___ The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with Section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth in 45 CFR Section 74.40 – Section 74.48.)

iii. ____ The State elects to provide financial management services using "agency with choice" organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.

B. __X__ The State elects to perform financial management services on behalf of participants' self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.