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State/Territory Name: Oregon

State Plan Amendment (SPA) #: 16-0008

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104

Division of Medicaid & Children's Health Operations

December 6, 2016

Lynn Saxton, Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, OR 97301

RE: Oregon State Plan Amendment (SPA) Transmittal Number 16-0008

Dear Ms. Saxton:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA) Transmittal Number 16-0008. This SPA amends Oregon's 1915(k) Community First Choice Program to remove language referring to the "live-in" program and "24-hour availability" of homecare workers and personal support workers as well as other technical revisions to align with program changes enacted to address requirements of the Federal Department of Labor regulations.

The SPA is approved effective September 1, 2016.

Thank you for the cooperation of your staff in the approval process of this amendment. If you have any additional questions related to this matter, please contact me or Gary Ashby at gary.ashby@cms.hhs.gov or (206) 615-2333.

Sincerely,

Digitally signed by David L. Meacham -S

[redacted]

David L. Meacham
Associate Regional Administrator

cc:
Lori A. Coyner, Oregon Health Authority
David Simnitt, Oregon Health Authority
Jesse Anderson, Oregon Health Authority
Dana Hittle, Oregon Health Authority

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO .0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **16-0008**

2. STATE: Oregon

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Medical Assistance

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
9/1/16

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1915(k) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $ (5.3M)
b. FFY 2017 $ (75.1M)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-K, Pages 2, 13-15, 18, 20-23, 31, 32-37, 39-41 (P&I)
~~Attachment 3.1-K, Pages 13-15, 18, 20-22, 32-37, 39-41, 47, 48, 48a, 50, 51~~ (P&I)

Attachment 4.19-B, Pages 20-23, 23a, 24-26 (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-K, Pages 2, 13-15, 18, 20-23, 31, 32-37, 39-41 (P&I)
~~Attachment 3.1-K, Pages 13-15, 18, 20-22, 32-37, 39-41, 47, 48, 50, 51~~ (P&I)

Attachment 4.19-B, Pages 20-23, 23a, 24-26 (P&I)

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to remove language referring to the "Live-in" program and "24 hour availability" of homecare workers and personal support workers and other technical revisions to align with DHS-program changes enacted to address the requirements of Federal Department of Labor regulations.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: The Governor does not wish to review any plan materials.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME Lori Coyner, MA

14. TITLE: Medicaid Director, OHA

15. DATE SUBMITTED: 9/29/16

16. RETURN TO:
Oregon Health Authority
Medical Assistance Programs
500 Summer Street NE E-35
Salem, OR 97301

ATTN: Jesse Anderson, State Plan Manager

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
9/29/16

18. DATE APPROVED:
12/6/16

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
9/1/16

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]
Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS,
Date: 2016.12.06 11:50:30 -08'00'

21. TYPED NAME:
David L. Meacham

22. TITLE:
Associate Regional Administrator

23. REMARKS:

11-14-16: State Authorized P&I change to boxes 8 and 9

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Community First Choice State Plan Option

The tool uses information regarding the individual's qualifying diagnosis, and may include IQ and adaptive impairment scores based on an assessment of functional areas to make the determination.

Once approved, the person-centered plan coordinator must review the individual's service needs at least annually and more frequently if the individual's functional needs change or if requested by the individual. The date of review and signature is required, indicating that the review has been completed and the individual continues to meet the Level of Care criteria. A case note of this will also be made to the individual's case management file.

All individuals considered for the Hospital Level of Care are assessed using the established tools for nursing facility and ICF/ID LOC, along with additional clinical criteria. The Clinical Criteria tool assesses and scores various care elements that the assessor expects to last six months or more. It measures nursing and other intervention needs, factoring in frequency and intensity of the care needed in the following: Skin/Physical Management; Metabolic: GI/Feeding; Neurological; Urinary/Kidney; Respiratory; and Vascular. Individuals must have a physician's signature that hospital level of care is required.

Individuals who are receiving medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must continue to meet all 1915(c) requirements and must receive at least one home and community-based waivered service per month. Individuals receiving services through CFC will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State plan, waiver, grant or demonstration but will not be allowed to receive duplicative services in CFC or any other available community-based services.

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All individuals receiving services will be contacted at least quarterly throughout the year (minimum of 1 contact every three months). Individuals with three or more high risk factors must be contacted at least monthly. One of the contacts must be face-to-face while others may occur either by phone or face-to-face depending upon the individual's preference.

The Department requires criminal background checks as a provider qualification and utilizes these background checks as a risk management tool. The Department assumes the cost of the background checks.

B. The State elects to include the following CFC permissible service(s):

1. X Expenditures relating to a need identified in an individual's person-centered plan of services that substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance. These include:

   Environmental Modifications. Environmental modifications are provided in accordance with 441.520(b).

   Assistive Devices. Assistive Devices means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living or instrumental activity of daily living. Coverage will be limited to devices and technology not covered by other programs and will be limited to $5000 per device or assistance based on an assessed need of the service recipient. Person-centered plan coordinators may request approval for additional expenditures through the DHS policy office prior to expenditure. Expenditures will only be made for the most cost effective device or assistance and must be approved by the Department for any expenditure over $500.

   Community Transportation. Community Transportation is provided to eligible individual to gain access to community-based state plan and waiver services, activities and resources. Trips are related to recipient service plan needs, are not covered in the 1115 medical benefit, are not for the benefit of others in the household, and are provided in the most cost-effective manner that will meet needs specified on the plan. Community Transportation services are not used to: 1) replace natural supports, volunteer transportation, and other transportation services available to the individual; 2) compensate the service provider for travel to or from the service provider's home.

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Home-Delivered Meals (HDM). HDMs are provided for participants who live in their own homes, are home-bound, are unable to do meal preparation, and do not have another person available for meal preparation. Payment for HDMs will not be allowed when individuals are receiving CFC services in a residential CBC setting. CBC residential providers must provide meal services. Provision of the home delivered meal reduces the need for reliance on paid staff during some meal times by providing meals in a cost-effective manner. Each HDM contributes an estimated one-third of the recommended daily nutritional regimen, with appropriate adjustments for weight and age. HDM providers bill the state Medicaid program directly for no more than one meal per day.

2. X Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides. These expenditures are limited to individuals transitioning from a nursing facility, IMD, or an ICF/ID to a home or community-based setting where the individual resides.

Service Limits

Service levels for community based services and allowable activities for in-home services are based on the individualized functional assessment of service needs. In-Home hourly allocation may be divided between support for ADLs, IADLs, and Health-Related Tasks. The following items will be based on the individual's functional assessment and identified as being unmet by other state plan services or natural supports:

- Assistance with Activities of Daily Living (ambulation, transferring, eating, cognition /behaviors, dressing, grooming, bathing, and hygiene), and
- Instrumental Activities of Daily Living (housekeeping, laundry, medication management, transportation, meal preparation, and shopping).

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Natural supports are identified during the person centered service planning process and utilized when available to the individual. Natural Supports are defined as resources available to an individual from their relatives, friends, significant others, neighbors, roommates and the community. Natural supports are determined to be available when an individual listed above is willing to voluntarily provide the identified services and the service recipient is willing to accept services from the natural support. If the natural support is unwilling or unable to provide the identified services, paid supports will be provided. Nothing in the natural support determination prevents the Department from paying qualified family members who are performing paid work. The state will not provide services or supports that are within the range of activities that a parent/legally responsible individual would ordinarily perform on behalf of a child without a disability or chronic illness of the same age.

Payment for home-delivered meals, chore services, home-care workers or personal support workers, community nursing services, personal emergency response systems, relief care providers, and environmental accessibility adaptations will not be allowed when individuals are receiving CFC services in a residential CBC setting. CBC residential providers must ensure their residents have access to substantially similar services as those living in their own homes.

Health related tasks will be limited to a need or needs, identified through the functional assessment and reflected in the person-centered plan.

Electronic back-up systems, mechanisms and any specialized or durable medical equipment necessary to support the individual's health or well-being will be limited to items approved in the services plan and are not to exceed $5,000 and payable only when other funding authorities such as Medicare, Medicaid or private insurance, disallow the item or service. Person-centered plan coordinators may request approval for expenditures beyond the limit through the DHS policy office prior to expenditure. Services must be the most cost-effective and approved by the Department.

Transition services will be limited to necessary services for individuals transitioning from an institution into a community-based or in-home program. Services will be based on an assessed need, determined during the person-centered service planning process and will support the desires and goals of the individual receiving services and supports. Final approval for expenditures will be through the DHS policy office prior to expenditure.

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(F) The State assures the collection and reporting of information, including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a CFC the choice to instead receive home and community-based services in lieu of institutional care.

(G) The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this option during the fiscal year.

(ii) The number of individuals that received such services and supports during the preceding fiscal year.

(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a CFC.

(H) The State assures that home and community-based attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws consistent with 441.570(d)(1)-(5)..

(I) The State assures it established a Development and Implementation Council prior to submitting a State Plan Amendment in accordance with section 1915(k)(3)(A). The council is primarily comprised of eligible individuals who are individuals with disabilities, elderly individuals and their representatives.

vi. Assessment and Service Plan

Level of Care assessments and functional needs assessments will occur prior to the development of the service plan. Person-centered plan coordinators conduct a full needs assessment, which includes a comprehensive discussion with the participant about the participant's functional abilities and strengths in completing activities of daily living and instrumental activities of daily living. Individuals will be actively involved in the functional needs assessment process and will have the opportunity to identify goals, strengths and needs.

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(3) Requires Full Assistance in Mobility, or Cognition, or Eating.

(4) Requires Full Assistance in Elimination.

(5) Requires Substantial Assistance with Mobility, Assistance with Elimination and Assistance with Eating.

(6) Requires Substantial Assistance with Mobility and Assistance with Eating.

(7) Requires Substantial Assistance with Mobility and Assistance with Elimination.

(8) Requires Minimal Assistance with Mobility and Assistance with Eating and Elimination.

(9) Requires Assistance with Eating and Elimination.

(10) Requires Substantial Assistance with Mobility.

(11) Requires Minimal Assistance with Mobility and Assistance with Elimination.

(12) Requires Minimal Assistance with Mobility and Assistance with Eating.

(13) Requires Assistance with Elimination.

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

Children being assessed for NF LOC are assessed using the Medically Involved Clinical Criteria tool as defined in OAR 411-300-0020. The clinical criteria tool scores based on needs for the child that are outside of the school setting. The assessment factors in age appropriate care needs when reviewing ADL and IADL abilities and limitations. The tool also factors in paramedical interventions that may be needed. These are areas that require physician's orders or RN delegation. The assessment scores points based on the intensity of assistance needed and severity and intensity of medical interventions.

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In order to meet the ICF/ID level of care, an individual must meet eligibility criteria as described in OAR 411-320-0080 for intellectual disability or developmental disability other than intellectual disability and have significant impairment in adaptive behavior. Person-centered plan coordinators complete the initial LOC assessment and reviews the level of care annually, or more frequently based on the functional needs of the individual, or at the request of the eligible individual. They assessments happen during a face-to-face meeting with the individual. The person-centered plan coordinator completes the assessment using personal observations of the individual, interviews with the individual and others with personal knowledge of the individual, and documentation of the individual's functioning from information in the individual's file, such as standardized tests administered by qualified professionals.

Once the person-centered plan coordinator completes the initial LOC they submit it to DHS.

DHS employs a Diagnosis and Evaluation Coordinator (D & E Coordinator), to assist with oversight and training person-centered plan Coordinators.

A component part of the LOC assessment is to confirm:

That the individual meets eligibility criteria as defined in OAR 411-320-0080 as a person with an intellectual disability or a developmental disability; and a significant need for supports in one or more of the following areas:

> Self Direction, Home Living, Community Use, Social, Self Care, Communication, Mobility, and Health & Safety.

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The Department uses a LOC tool that indicates impairments are explicitly related to eligibility. Additionally, eligibility specialists sign an attestation verifying the eligibility as intellectually disabled or developmentally disabled under
OAR 411-320-0080. The diagnostic area will include additional information regarding the individual's qualifying diagnosis, and IQ and adaptive impairment scores used to make the determination.

The Hospital LOC assessment is based on an acute care hospital clinical criteria tool that assesses the need for medical interventions based on a point system. The points are determined by the severity, frequency and amount of care or medical oversight needed in the following areas: Urinary & Nephrology (including dialysis), Gastroenterology & Feeding, Metabolic, Neurological, Skin & Physical Management, Respiratory, and Vascular. The tool utilizes age factors in areas where medical interventions might be different for children. Scoring is only allowed for interventions that must be conducted at least once per week and are expected to last for at least six months. A physician and a person-centered plan coordinator must agree that the individual can be safely served in a community based setting.

Person-Centered Service Plan Requirements: The person-centered service plan will reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. The plan must:
(1) Reflect that the setting in which the individual resides is chosen by the individual.
(2) Reflect the individual's strengths and preferences.
(3) Reflect clinical and support needs as identified through an assessment of functional need.
(4) Include individually identified goals and desired outcomes.
(5) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports.

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(Natural supports cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual.)
(6) Reflect risk factors and measures in place to minimize them, including individualized backup plans.
(7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her.
(8) Identify the individual and/or entity responsible for monitoring the plan.
(9) Be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation.

Person-Centered Service Plan Development Process: Local, state or contracted case management entities have the responsibility for determining the individual's level of care, performing a functional needs assessment and developing a person-centered service plan in accordance with the individual's choice of services to be provided. The service planning process includes evaluating all available resources and funding mechanisms to meet the individual's needs. A primary goal is to develop a person-centered service plan that identifies strengths, desires, goals and existing supports and to develop a comprehensive plan that honors the dignity, strength and autonomy of the individual and that supports their right to be as integrated in the community as they choose.
The individual or designated representative decides who may or may not be included in person-centered service plan development discussions and contribute to the individual's person-centered service plan. Person-centered plan coordinators assist the individual in selecting and notifying other participants in the assessment and planning process. Person-centered plan coordinators meet with each individual (and family or representative, as appropriate) on a schedule that assures eligibility determinations and assessments are completed within 45 days of request of services.

The person-centered plan coordinator must address the needs of the participant through the service plan and provide the participant a copy of the service plan. The eligible individual will have the opportunity to review and modify the plan. The person-centered plan coordinator will work with the individual to identify the individual's goals, needs and preferences for the way that services are provided and received. Local, state or contracted case management entities give individuals information about the array of options available to them and provide choice counseling. The person-centered plan coordinator will ensure that providers have a copy of the relevant tasks from the service plan for which they are responsible.

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Person-centered plan coordinators work with the individual to ensure that their freedom and choices are being honored.

7. Individuals are able to have visitors of their choosing at any time;

Individuals have the ability to choose their visitors and when their visitors come to see them. Individuals may choose when their visitors are allowed to visit. Providers may discuss social covenants about the timelines to minimize disruption and negative impacts to other residents. Regardless, of these social covenants, providers must not limit visitors for their convenience.

Individuals are encouraged to maintain the maximum level of control possible while acknowledging that the individuals are sharing living space with other individuals. Restrictions must not be for the convenience of the provider and must be in the best interest of all residents or based on necessary restrictions identified in the person-centered plan. Facilities may limit access to visitors who are disruptive, violent or have a history of committing illegal activities.

8. The setting is physically accessible to the individual.

All facilities must be physically accessible to the individuals they serve.

Provider owned or controlled residential settings are not:

a. Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment.

b. Located in a building on the grounds of or immediately adjacent to a public institution

c. Located in a building on the grounds of or immediately adjacent to disability-specific housing.

The state will follow approved Statewide Settings Transition Plan. Oregon assures that the setting transition plan included with this 1915(k) State Plan Amendment will be subject to any provisions or requirements in the State's approved Statewide Settings Transition Plan. The State will implement any applicable required changes upon approval of the Statewide Settings Transition Plan and will make conforming changes to its 1915(k) State Plan Amendment, as needed, when it submits the next amendment. The most recent version of the Statewide Settings Transition Plan can be found at:https://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCBS/Documents/Oregon%27s%20Revised%20Transition%20Plan%20with%20Technical%20Edits%20-%20Oct%202016.docx

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viii. Qualifications of Providers of CFCO Services

Adult Day Providers- Licensing and certification requirements are OAR 411-066-0000 through 411-066-0015. Adult Day Service (ADS) programs that contract with the Department to provide services must be certified.

Adult Foster Care- Licensing requirements at OAR 411-050-0600 – 0690 OAR 309-040-0030 through 309-040-0330; and 411-360-0010 through 411-360-0310. Local CDDPs, Branch offices, DHS Central Office, and OHA/HSD are responsible for verification of provider qualifications upon initial license and annual renewal.

Adult Group Home- Contracted and State Operated Licensing requirements at OAR 411-325-0010 through 411-325-0480 and agency certification requirements at OAR 411-323-0010 through 411-323-0070. DHS Central Office is responsible for verification of provider qualifications biennially.

Assisted Living Facility- Licensing requirements at OAR 411-054-0000 - 0300. The DHS Client Care Monitoring Unit is responsible for verification of provider qualifications at initial license and renewal (every 2 years).

Behavior Support Service Providers- Behavior consultants are certified by the state or approved by a Department Designee. The Department is responsible for verification of provider qualifications initially and at least every 5 years.

Children's Developmental Disability Foster Care- Certification requirements at OAR 411-346-0100 through 411-346-0230 or 413-200-0300 through 413-200-0396. DHS, ODDS or Child.

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Welfare, will determine compliance based on receipt of the completed application material, an investigation of information submitted, an inspection of the home, a completed home study and a personal interview with the provider. Certification requirements are reviewed biennially.

Community Nursing Services – Providers are enrolled Medicaid providers that are licensed registered nurses, licensed Home Health agencies; or Licensed In-Home agencies. Providers meet minimum requirements established in OARs including passing a criminal background check and having minimum direct care experience in LTC programs.

Community Living Supports Agency Provider- Providers are certified under OAR Chapter 411, Division 323 and endorsed to requirements described in OAR Chapter 411, Division 450. People providing direct services to a recipient must pass a Criminal History Check conducted by the state at a minimum of every two years. The agency must demonstrate proof of liability and operational insurance coverage as described in OAR 411-323-0030(3)(d). DHS verifies the qualifications of the provider every 5 years. Additionally, the Department can review at any time for cause. These providers are authorized to provide ADL, IADL and health related tasks during the course of attendant care, skills training, and relief care supports.

Community Transition Service Providers- Provider requirements at OAR 461-155-0526 Branch offices are responsible for verification prior to authorizing service and payment
Community Transportation, Individual provider- Providers are enrolled Medicaid providers. Valid Oregon Driver's License is required. Individuals providing transportation must be at least 18 years of age, have a valid driver's license, a good driving record, and proof of insurance. People providing direct services to a recipient must pass a Criminal History Check conducted by the state. People providing direct services in the family home or working alone with a recipient must be at least 18 years of age; have ability and sufficient education to follow oral and written instructions and keep simple records; have training of a nature and type sufficient to ensure that the person has knowledge of emergency procedures specific to the individual being cared for; understand requirements of maintaining confidentiality and safeguarding individual information; display capacity to provide good care for the individual; and have the ability to communicate with the individual. With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

Community Transportation, Bus/Taxi- Transportation provided by common carriers, taxicab or bus will be in accordance with standards established for those entities.

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Community Transportation, Agency Provider- Licensing and certification requirements at OARs 411-325-0010 through 411-325-0480; ; 309-035-0100 through 309- 035-0190; OARs 309-041-0550 through 309-041-0830; 411-345-0010 through 411-345-0300; 411-360-0010 through 411-360-0310; 411-328-0550 through 411-328-830; 411-346-0100 through 411-346-0230; 411-450-0080. People providing transportation must also have a valid driver's license, a good driving record, and proof of insurance. With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

Developmental Disabilities Support Services Provider Organization- Providers are certified under OAR 411-323-0010 through 411-323-0070 and endorsed to requirements at OAR 411-340-0030, OAR 411-340-0040, OAR 411-340-0050, OAR 411-340-0070, OAR 411-340-0080, and OAR 411-340-0090, and OAR 411-340-0170. DHS verifies the qualifications of the provider at the time of the initial certification and every 5 years. Additionally, the department can review at any time for cause.

Group Care Homes for Children- Certification requirements at OAR 411.349-0000 through 411-3490020; 411-325-0010 through 411-325-0480; or 413-215-0000 through 413-215-0883. DHS Central Office is responsible for verification of provider qualifications biennially.

Habilitation Agency Provider - Providers are certified and endorsed under OARs 411-345-0000 through 411-345-0300 and OAR 411-323-0010 through 411-323-0070. People providing direct services in the family home or working alone with a recipient must pass a Criminal History Check conducted by the state at a minimum of every two years.

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Demonstrate proof of liability and operational insurance coverage as described in OAR 411-323-0030(3) (d). DHS verifies the qualifications of the provider every 5 years. Additionally, the department or the can review at any time for cause. These providers are authorized to provide ADL, IADL and health related tasks during the course of community living and inclusion supports and alternative to employment services.

Home Care Worker- Certification requirements at OAR 411-031-0020 - 0050. Branch offices are responsible for verification of provider qualifications at initial authorization. Criminal background checks are conducted initially and every 2 years.

In-Home Care Agency- Licensing requirements at OAR 333-536-0000 through 0100 and OAR 411-030-0002 through 0090. DHS Central office is responsible for verification of provider qualifications upon the execution and renewal of contracts.

Personal Support Worker- Requirements for qualification at OAR 411-375-0020. The Department is responsible for verification of these provider qualifications. Criminal background checks are conducted initially and every 2 years. . Personal Support Workers providing transportation must also have a valid driver's license, a good driving record, and proof of insurance as verified by the CDDP, Brokerage, or the Department. A representative of the CDDP, brokerage, the Department or family will verify that the person can provide the care needed by the individual. The common law employer (employer of record) is responsible for informing and training regarding the specific care needs of the individual. With cause, providers may be subject to investigation or inquiries by the CDDP or the Department.

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Local Transportation Authorities- DHS/Provider contract specifications. DHS Central Office is responsible for verification of provider qualifications upon execution of renewal of contracts. Contracts are renewed every 2 years.

Residential Care Facilities- Licensing requirements at OAR 411-054-0000 - 0300. The DHS Client Care Monitoring Unit is responsible for verification of provider qualifications at initial license and renewal (every 2 years).

Residential Treatment Facility for Mentally or Emotionally Disturbed Persons- License Licensed by the Oregon Health Authority under OAR 309-035-0110. Licenses are renewed every two years.

Skills Trainers- are hired or monitored by licensed, certified or specialty programs including Adult Foster Care, Adult Group Homes, Assisted Living Facilities, Community Living Supports Providers, Developmental Disabilities Support Services Provider Organizations, Group Care Homes, Habilitation Agency Providers, In-home Care Agencies, In-Home Support Provider Agency, Residential Care Facilities, Residential Treatment Facilities/Homes Specialized Living Services and Supported Living Agency providers that have demonstrated expertise in serving the targeted individuals.

Specialized Living Services- Certification requirements at OAR 411-065-0000 through 0050. Branch offices are responsible for verification of provider qualifications prior to executing a contract and annually thereafter. These service providers are authorized to provide ADL, IADL and health related tasks as well as acquisition services.

Supported Living Agency Provider - Providers are certified and endorsed under OARs 411-328-0550 through 411-328-0830 and OAR 411-323-0010 through 411-323-007. People providing direct services in the recipient's home or working alone with a recipient must pass a criminal history check conducted by the state at a minimum of every two years. T The agency must demonstrate proof of liability and operational insurance coverage as described in OAR 411-323-0030(3) (d). Provider qualifications must be rechecked every 5 years. Additionally, the department or the CDDP can review at any time for cause.

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ix. Quality Assurance and Improvement Plan

The DHS Quality Assurance Teams (QAT) and policy staff members review and monitor the accuracy and consistency of operational and administrative functions performed by all state and local contracted entities through an ongoing process. Within a two year time frame, all state and contracted entities are fully reviewed. State and contracted entities also develop management plans that support key quality strategies and to address areas of concern: such as timeliness, accuracy, appropriateness of services, services billed are actually received, compliance with State and Federal regulation, program outcomes, eligible individual satisfaction and cost effectiveness.

The process of evaluation involves Quality Assurance Team 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 eligible individual satisfaction.

The QA Team records findings using program specific standardized tools and issues a formal finding in a report to the state or contracted entity identifying trends in policy and rule application. The state or contracted entity must submit a plan of correction to DHS within 30 days of receipt of this report that addresses any issues found in the QA Team report. DHS then issues a final report to the state or contracted entity. The Quality Assurance team revisits the state or contracted entity 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 QA Team include file reviews, onsite reviews, interviews and assessments with individuals receiving services, and service plan reviews.

Oregon has implemented the National Core Indicators project. The project gives the Department information from eligible individual's perspectives about Developmental Disabilities services. Oregon has implemented a system (Aspen) allowing the Office of Licensing and Regulatory Oversight increased access to information for licensing and quality assurance activities.

The Medicaid/CHIP Operations Coordination Steering Committee (MOCSC) is an internal leadership and governance body of OHA and DHS, chartered in accordance with the Inter-Agency Agreement (IAA). MOCSC is co-chaired by representatives of OHA and DHS appointed by the OHA/DHS Joint Operations Steering Committee (JOSC).

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- **Provider Capacity and Capabilities**: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- **Participant Safeguards**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- **Participant Rights and Responsibilities**: *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- **Participant Outcomes and Satisfaction**: *Participants are satisfied with their services and achieve desired outcomes.*
- **System Performance**: *The system supports participants efficiently and effectively and constantly strives to improve quality.*

System performance measures, outcome measures and satisfaction measures include the following:

1. The percentage of CFC applicants for whom state or local contract staff has completed a level-of-care assessment to determine institutional level of care eligibility prior to enrollment. Numerator = number of enrolled applicants who have a completed level of care assessment. Denominator = total number of files reviewed of enrolled applicants for CFC services.

2. The percentage of CFC participants receiving an annual redetermination of institutional LOC Numerator: All CFC participants with a LOC redetermination completed prior to 12 months from their initial determination or last redetermination. Denominator: All files reviewed of CFC participants for whom an annual LOC redetermination is required.

3. The percentage of CFC participants whose CFC eligibility was determined using the appropriate processes and instruments and according to the approved description. Numerator: CFC participants whose CFC eligibility was determined using the appropriate processes and instruments according to the approved description. Denominator: All files reviewed of CFC participants found eligible for services.

4. The percentage of providers of CFC services plan that meet required licensure and/or certification under Oregon Administrative Rule. Numerator: Providers that prior to delivering CFC services initially met and continue to meet licensure and/or certification requirements. Denominator: All files reviewed in which providers delivering CFC services require licensure and/or certification.

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5. The percentage of providers who are trained per Oregon Administrative Rules and the approved CFC. - Numerator: CFC service providers that are trained per Oregon Administrative Rules and the approved CFC. - Denominator: All CFC services provider for files reviewed.
6. The percentage of participants whose service plans address assessed needs and personal goals per approved procedures. Numerator: Participants whose service plans address assessed needs and personal goals per approved procedures. Denominator: All CFC participant service plans reviewed.
7. All participants have a written and authorized service plan in accordance with Oregon Administrative Rules. Numerator: All participants with a written and authorized service plan in accordance with OAR. Denominator: All participants' service plans reviewed.
8. The percentage of service plans that are updated or revised annually. Numerator: Plans that are renewed within 12 months from the previous service plan. Denominator: All service plans reviewed.
9. The percentage of service plans that are revised when warranted by a change in needs. Numerator: Service plans that are revised when participant needs change. Denominator: All service plans reviewed.
10. The percentage of services delivered in accordance with what is specified in the service plan including the type, scope, duration and frequency. Numerator: Service plans for which services delivered are in accordance with the type, scope, duration and frequency specified in the plan. Denominator: All service plans reviewed.
11. Individuals are offered the choice of CFC services and offered choice of qualified providers. Numerator: Participants who are offered choice of CFC services and qualified providers. Denominator: All CFC participants reviewed.
12. Individuals are offered the choice between CFC services and institutional care. Numerator: Number of participants offered the choice between CFC services and institutional care. Denominator: All CFC services recipients reviewed.
13. The percentage of participants who are victims of substantiated abuse, neglect or exploitation. Numerator: Participants who are victims of substantiated abuse, neglect or exploitation. Denominator: All CFC participant files reviewed.

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14. Identified individual risk and safety considerations are addressed taking into account the individual's informed and expressed choices. Numerator: Identified risks and safety considerations addressed taking into account the individual's informed and expressed choices. Denominator: All CFC participant files reviewed.

15. The percentage of claims that are authorized and paid for in accordance with reimbursement specified in the approved CFC. Numerator: Reimbursements that are authorized and paid for in accordance with the methods specified in the approved CFC. Denominator: All reimbursements for files reviewed.

16. Percent of individuals who express that their services and supports are meeting their needs. Numerator: Number of service recipients who express their service needs are being met. Denominator: All service recipients who respond to the satisfaction survey.

18. Percent of individuals who express that they are able to direct their services. Numerator: Number of service recipients who express they are able to direct their services. Denominator: All service recipients who respond to the satisfaction survey.

Measurement of individual outcomes associated with the receipt of community-based attendant service and supports.

Every two years, DHS will survey statistically valid sample of individuals receiving CFC services to determine their satisfaction and outcomes related to the CFC services. The survey will include an assessment of the individual's opinion in progress towards goals identified by the individual in their person-centered service plan. The survey will also address the quality of care about the service provider. DHS will monitor length of stay in the service setting to determine the stability of the person-centered service plan.

DHS shall ensure that all individuals receiving CFC services and supports have access to all of the protections in the state's abuse, neglect and exploitation protection including mandated reporting, investigation and resolution of allegations of neglect, abuse, and exploitation. Oregon law defines mandatory reporters, types of abuse and consequence and remediation in appropriate cases. DHS shall follow these statutes and the corresponding administrative rules. In addition to abuse reports required by statute for older adults, people with developmental disabilities and people with mental illness, all staff shall report abuse for individuals under age 65. Protective service workers will investigate any allegation.

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Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of services provided under the Community First Choice Option. **The agency's fee schedule is effective for services provided on and after July 1, 2016**. Rates are published at: http://www.oregon.gov/dhs/spd/pages/provtools/index.aspx and Personal Support Workers rate are published at http://www.dhs.state.or.us/spd/tools/dd/cm/In-Home-Expenditure-Guidelines.pdf

The following 1915(k) provider types are reimbursed in the manner described:

Assisted Living Facility- Assisted Living Facility rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Assisted Living Facilities rates are paid based on the individual's assessed needs. The individual's needs result in a reimbursement in one of 5 payment levels. The different payment levels reflect the individual's acuity and ADL needs as follows:

Level 1 -- All individuals qualify for Level 1 or greater.

Level 2 -- Individual requires assistance in cognition/behavior AND elimination or mobility or eating.

Level 3 -- Individual requires assistance in four to six activities of daily living OR requires assistance in elimination, eating and cognition/behavior.

Level 4 -- Individual is full assist in one or two activities of daily living OR requires assistance in four to six activities of daily living plus assistance in cognition/behavior.

Level 5 -- Individual is full assist in three to six activities of daily living OR full assist in cognition/behavior AND one or two other activities of daily living.

Behavioral Support Consultants- DHS developed rates for Behavioral Coaches and Behavioral Consultants based on the usual and customary charges for similar services provided within Oregon.

Community Transition Providers- Payments are based on lowest market rate as evidenced by at least three bids.

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Home Accessibility Adaptations Providers- A scope of work is created for the adaptation. From the scope of work, bids or estimates of the cost of the adaptation are received from multiple qualified providers. The provider who submits the most cost-effective bid or estimate is chosen to complete the home adaptation.

Home Delivered Meal Providers- Home Delivered Meal rates are established utilizing detailed cost reports. The Department conducts an analysis of the cost reports. A weighted average is used to determine a statewide reimbursement rate.

Homecare and Personal Support Workers- Reimbursement rates for Home Care Workers and Personal Support Workers that provide In-Home services are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at 2-year intervals. Mileage reimbursement is collectively bargained, as well.

Community Transportation Providers- Contract rates for transportation brokerages are individually negotiated with the provider. The rates are based on a cost allocation model supplied by each transportation brokerage.

APD Adult Foster Care- Medicaid reimbursement rates for APD Adult Foster Home providers are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at two year intervals. The collective bargaining process is a public process.

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

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(A) The individual is full assist in mobility or eating or elimination;

(B) The individual demonstrates behaviors that pose a risk to the individual or to others and the provider must consistently intervene to supervise or redirect; or

(C) The individual's medical treatments, as selected and documented on the SPD CA/PS, require daily observation and monitoring with oversight by a licensed healthcare professional, no less than quarterly, and the facility has trained staff to provide such service and does provide the service.

DD Children's Foster Care- A functional needs assessment is used to measure the support needs of an individual and determine rates for Adult FC and CDDFC based on those assessed needs.

Based on the answer selection, the functional needs assessment will then calculate a rate for the individual commensurate with the level of identified need. The rates from the various support needs area categories are then totaled to get an overall FC service rate. The rate structure is designed to fall within rate ranges based on groupings of level of need. There is a process for specific rate increases by exception if there is an identified need that is outside the standard assessment parameters, such as 2:1 support for a specific support task.

DD Adult Foster Care- The functional needs assessment is used to measure the support needs of an individual and determine rates for Adult FC and CDDFC based on those assessed needs.

Based on the answer selection, the functional needs assessment will then calculate a rate for the individual commensurate with the level of identified need. The rates from the various support needs area categories are then totaled to get an overall FC service rate. The rate structure is designed to fall within rate ranges based on groupings of level of need. There is a process for specific rate increases by exception if there is an identified need that is outside the standard assessment parameters, such as 2:1 support for a specific support task.

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Medicaid reimbursement rates for Adult Foster Care providers are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at two year intervals. The collective bargaining process is a public process.

Contracted Group Care Homes for Adults- Each individual's support needs be assessed using a functional needs assessment annually, when an individual requests it or when the individual's needs change. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual Level of Care (LOC) redeterminations, annual Plan of Care (POC) meetings, and when changes are brought to the person centered plan coordinator's attention, an individual's provider of service, family member, friend or member of the community.

- The functional needs assessment collects information about the person's support needs . This information is used to match the individual with one of several levels of expected support need.
- A funding tier is assigned. Each funding tier corresponds to one of the functional needs assessment derived expected support levels.
- Each funding tier contains several rates that reflect appropriate funding for a person with that particular level of support need, adjusted by the size of setting (licensed capacity) in which they reside.

State Operated Group Care Homes for Adults- Each individual's support needs are assessed using a functional needs assessment. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual LOC redeterminations, annual POC meetings, and when changes are brought to the person centered plan coordinator's attention, an individual's provider of service, family member, friend or member of the community.

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State Operated Group Care Homes for Adults-(Cont)-The rate setting methodology incorporates other payroll expenditures (OPE), allowable administration percentages, and other costs associated with operating a business. It also incorporates information on revenue and expenses about the service so that DHS can assure that the total funding does not exceed the cost of operating the site.

Group Care Homes for Children- Group home rates are set based on children's needs within the group home setting. The rate setting budget tool is completed on a DHS mandated format, using DHS established rates. The rate setting budget tool takes into account the broad range of children's needs, including staffing level, behavior consultation, specialized interventions tailored to the child's disability, and 1:1 staffing. There is a process for specific rate increases by exception if there is an identified need that is outside the standard assessment parameters, such as 2:1 support for a specific support task. The process is facilitated through the DHS Residential Specialist coordinating the child's care. These exceptional need rates are reviewed quarterly by the DHS Residential Specialist and Residential Manager for continuing need. Proposed staffing, management oversight, and consultation are entered into the budget tool along with projected expenses for program services and supplies, and transportation.

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The rate setting budget tool incorporates OPE, allowable administration percentages, and other costs associated with operating a business. The tool incorporates information on revenue and expenses about the service site, so that DHS can assure that the resulting budget reflects ONLY the supports for the specific individual and that the total site funding does not exceed the cost of operating the site.

Residential Care Facility Regular- Residential Care Facility (Regular) rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Residential Care Facilities are paid a base rate with add-ons for specific medical, behavioral and ADL needs. The reimbursement rate may include the base rate with up to three add-on payments. Add-ons are paid if

The individual is full assist in mobility or eating or elimination;

(B) The individual demonstrates behaviors that pose a risk to the individual or to others and the provider must consistently intervene to supervise or redirect; or

(C) The individual's medical treatments, as selected and documented on the SPD CA/PS, require daily observation and monitoring with oversight by a licensed healthcare professional, no less than quarterly, and the facility has trained staff to provide such service and does provide the service.

Residential Care Facility Contract- Residential Care Facility (Contract) rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Contracted rates are established for providers targeting a specific population and negotiating a specific rate for services provided to any individual within that target population. There are two types of contracted rates:
Supplemented Program Contract: A supplemented program contract pays a rate in excess of the published rate schedule to providers in return for additional services delivered to target populations.
Specific Needs Setting Contract: A specific needs setting contract pays a rate in excess of the published rate schedule to providers who care for a group of clients all of whose service needs exceed the service needs encompassed in the base payment and all add-ons. The provider must show the additional costs associated with providing care to the target population.

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Contracted rates are approved centrally. The provider submits a proposal for a contracted rate. A committee at DHS Central Office consisting of both program staff/management and rate staff/management review the proposal and determine if the provider meets the criteria. Contracted rates are renegotiated at contract renewal, usually at 1-2 year intervals.

Specialized Living Services Provider- Contract rates for specialized living providers are individually negotiated with the provider.

Community Registered Nurses- Community Registered Nurses are paid an hourly rate based on the current Department Published Rate Schedule. Rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. The Community RN will request prior-authorization and submit claims for client services utilizing billing codes per instructions in the Community RN Service Policy and Procedure Manual.

Emergency Response Providers- Rates are established using usual and customary local market rates.

Adult Day Providers- Rates are established using usual and customary local market rates.

Supported Living (SL) Agency Providers- The SL rate is individualized and based on the agency support and level of staffing required to meet the individual's assessed support needs as determined in the service plan. The SL budget is completed on the DHS mandated budget tool using DHS established rates for direct care staff and administrative costs.

Habilitation Agency Providers- The Habilitation budget tool is individualized and based on what level of staff and agency supports are required to meet specific individual service needs. The budget tool is completed on DHS mandated formats, and uses DHS established rates for direct care staff and administrative costs.

Exceptional Rate Payments- Exceptional rate payments may be made for services provided in Adult Foster Homes, Residential Care Facilities, and In-Home Services recipients. The services provided under an exceptional rate are for direct services provided to an individual. These are exceptional payments made to providers for services, documented in the Plan of Care, that require additional levels of skill, additional staffing or more hours to provide care on the part of the provider.

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The provider's skill level relates to the provider's ability to provide services to an individual with complex medical or behavioral needs. The provider may need to hire additional staff with additional knowledge or abilities consistent with the needs of the individual specifically to provide care to that individual. Additional staffing may be the result of an individual who needs two-person transfers or an individual with unscheduled nighttime needs that precludes the primary provider from being able to sleep for more than 4 hours in a night.

Individuals needing ventilator care may require multiple providers that have fairly extensive knowledge of the provision of ventilator care. The payments are requested at a rate above the scheduled rate for the individual's assessed need.

Rates paid to community-based facility providers are an all-inclusive rate intended to cover the individual's needs identified in the person-centered service plan. Rates do not include the costs for room and board.

Rates paid to providers of in-home services include an hourly rate and may include the taxes and benefits associated with the compensation of Home Care and Personal Support Workers. Home Care Workers, Personal Support Workers may receive exceptional or enhanced rates based on the needs of the consumer and/or special training or certification of the provider.

Exceptional payments for services provided by in-home providers are made for the provision of in-home services, documented in the Plan of Care, that exceed the maximum number of hours of service under rule. Based on the defined needs of the individual. All exceptional rate payments are pre-approved centrally OAR 411-027-0000 and 0050 document the services and requirements to document the need for exceptional rate payments to providers. Payment rates are the same as those for in-home services described above.

Rate variances for services received by individuals are based on a documented need in the plan of care that requires additional support or staffing that cannot be met using the standard rate ranges. Providers must demonstrate the ability to meet the individual's support needs using the additional funds provided.

Payments made for State plan services under 1915(k) authority do not duplicate payments made for similar services under 1915(c), 1915(i), 1915(j), or 1115 authorities.