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State/Territory Name: Oregon

State Plan Amendment (SPA) #: 18-0004

This file contains the following documents in the order listed:

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

July 2, 2018

Patrick Allen, Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, Oregon 97301-1079

RE: Oregon State Plan Amendment (SPA) Transmittal Number 18-0004

Dear Mr. Allen:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Oregon State Plan Amendment (SPA) Transmittal Number 18-0004. This SPA seeks to make changes to the 1915(k) Community First Choice state plan option. This SPA is approved effective July 1, 2018, as requested by the state.

If you have any questions, please contact me or your staff may contact Bill Vehrs at bill.vehrs@cms.hhs.gov or (503) 399-5682.

Sincerely,

Digitally signed by David L. Meacham -

[redacted]

David L. Meacham
Associate Regional Administrator

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: **18-0004**

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
7/1/18

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 2018 $ 379,294
b. FFY 2019 $ 1,517,178

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-K, page 1-3, 5-7, 9-11,13-15, 18-19, ~~21-24, 31-32, 35,35a, 39,43~~ (P&I)
21-24, 31-32, 35, 39, 42, 43
Attachment 4.19-B, pages 23, 23a, ~~23b~~ (P&I) , 25, 26

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-K, page 1-3, 5-7, 9-11,13-15, ~~18-19, 21-24, 31-32, 35, 39, 43~~ (P&I)
18-19, 21-24, 31-32, 35, 39, 42, 43
Attachment 4.19-B, pages 23, 23a, 25, 26

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to revise the K state plan option.

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 David Simnitt

14. TITLE: Interim State Medicaid Director, OHA

15. DATE SUBMITTED: 4/10/18

16. RETURN TO:
Oregon Health Authority
Medical Assistance Programs
500 Summer Street NE E-65
Salem, OR 97301

ATTN: Jesse Anderson, State Plan Manager

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 4/10/18

18. DATE APPROVED: 7/2/18

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/18

20. SIGNATUR[redacted]
Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS,

21. TYPED NAME: David L. Meacham

22. TITLE: Associate Regional Administrator

23. REMARKS:

6/1/18 - State authorized P&I change to blocks 8 and 9
6/21/18-State authorized P&I change to block 8

FORM HCFA-179 (07-92)

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

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

Community First Choice State Plan Option

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

Community First Choice Option services are available to State plan eligible groups as described in Section 2.2-A of the State plan. These individuals are eligible for medical assistance under the State plan and are in an eligibility group that includes Nursing Facility services or are below 150% of federal poverty level if they are in an eligibility group that doesn't include Nursing Facility services.

The State, through the person-centered plan coordinator or state trained assessor will determine initially, and at least annually, that individuals require the level of care provided in a hospital, a nursing facility, an intermediate care facility for Individuals with Intellectual Disabilities (ICF/ID), an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over. Level of Care (LOC) for individuals under age 21 and 65 and over needing psychiatric services is determined using hospital level of care criteria. Different tools are utilized in order to accurately assess an individual's specific needs based on the institutional Level of Care being assessed.

The "Client Assessment and Planning System (CAPS)" is the tool used to establish nursing facility level of care. It is a single entry data system used for completing a comprehensive and holistic assessment, surveying the individual's physical, mental, and social functioning, and identifying risk factors, individual choices, and preferences, and the status of service needs. The tool allows for identification of needs being met utilizing natural supports, state plan and waivered services, thus allowing for a full and comprehensive assessment and service plan. The CAPS documents the level of need and calculates the individual's service priority level (in accordance with OAR chapter 411, division 015), calculates the service payment rates, and accommodates individual participation in service planning. Individuals are actively involved in the assessment process and will have the opportunity to identify goals, strengths and needs. They will be allowed to have anyone they would like to participate in the assessment process.

A standardized level of care assessment tool is used to determine whether an individual meets the institutional criteria for ICF/IDD. The LOC assessment ensures that the impairments indicated are explicitly related to eligibility and meets the criteria for a significant impairment.

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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 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 Level of Care assessment form and MFCU clinical criteria. The MFCU Clinical Criteria combined with the Level of Care Assessment Form are the complete level of care evaluation. 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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For Individuals eligible under section 1902(a) (10)(A)(ii)(VI) of the Act who continue to meet all of the 1915(c) waiver requirements and who are receiving at least one 1915(c) waiver service a month, excess income determined under 42 C.F.R. 435.726 is applied, in addition to the cost of 1915(c) waiver services, to the cost of 1915(k) services. Therefore, excess income is applied to both 1915(c) waiver and 1915(k) services.

The LOC assessment is just one step in the planning process. Another step is the functional needs assessment that identifies the needs of the individual that must be addressed to ensure their safety and well-being and to ensure that individuals do not become unnecessarily institutionalized. The person-centered service plan (PCSP), that is individualized to address the individual's strengths, supports, goals and ensures their independence, dignity and well-being, is also completed.

ii. Service Delivery Models

__X__ Agency Model - The Agency Model is based on the person-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by entities under a contract.

_____ Self-Directed Model with service budget – This Model is one in which the individual has both a service plan and service budget based on the person-centered assessment of need.

____ Direct Cash
____ Vouchers
____ Financial Management Services in accordance with 441.545(b) (1).
____ Other Service Delivery Model as described below:

iii. Service Package

A. The following are included CFC services (including service limitations):

Attendant services and supports assist in accomplishing activities of daily living, instrumental activities of daily living and health related tasks through hands-on assistance, supervision, or cueing.

Services may be provided in the individual's home through enrolled homecare workers, personal support workers, in-home agencies or in a licensed, certified or endorsed community programs/settings of their choice.

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The State will cover IADL supports including light housekeeping, laundry, medication management, meal preparation, shopping, and chore services.

- Chore Services are not housekeeping and are not included in the "Service supports" listed above. These services are intended to ensure that the individual's home is safe and allows for independent living. Specific services include heavy cleaning to remove hazardous debris or dirt in the home and yard hazard abatement to ensure the outside of the home is safe for the individual to traverse and enter and exit the home.

ADL and IADL supports will be provided by enrolled homecare workers, personal support workers, in-home agencies or in a licensed, certified or endorsed community setting of the individual's choice.

The state will provide Long-term Care Community Nursing Services (LTCCNS) to support health related tasks within the state's nurse practice act. These services include nurse delegation and care coordination for eligible individuals living in their own home or a Foster Home. This service does not include direct nursing care and the services are not covered by other Medicaid spending authorities.

"Delegation means that a Registered Nurse authorizes an unlicensed person to perform a task of a nursing care in selected situations and indicates that authorization in writing. The delegation process includes nursing assessment of a client in a specific situation, evaluation of the ability of the unlicensed persons, teaching the task, ensuring supervision of the unlicensed person and re-evaluating the task at regular intervals." These services are designed to assist the individual and care provider in maximizing the individual's health status and ability to function at the highest possible level of independence in the least restrictive setting.

Services include:

- Evaluation and identification of supports that minimize health risks, while promoting the individual's autonomy and self-management of healthcare;
- Medication reviews;
- Collateral contact to the person-centered plan coordinator regarding the individual's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered service plan; and
- Delegation of nursing tasks, within the requirement of Oregon's nurse practice act, to an individual's caregivers so that caregivers can safely perform health related tasks.

The following list identifies criteria that may lead to a referral for LTCCNS.

- Need for the eligible individual, family member or care provider education;
- Need for delegation of a nursing care task;
- Medication safety issues or concerns;
- Unexpected increased use of emergency care, physician visits or hospitalizations;
- Changes in behavior or cognition;
- Nutrition, weight, or dehydration issues;
- Pain Issues;
- History of recent, frequent falls;
- Potential for skin breakdown or recently resolved skin breakdown; and
- Eligible individual who does not follow medical advice.

Long-term Care Community Nurses also assist in providing safe and appropriate community care supports and managing chronic diseases. Services are specific addressing health related tasks and do not duplicate services provided through other state plan or waiver authorities. LTCCNS provide person-centered plan coordinators, care providers and health professionals with information that they need to maintain the individual's health, safety, and community living situation while honoring their autonomy and choices (OAR 411-048-0150 (2)(a).

The LTCCN services may be delivered by the following enrolled Medicaid providers:

- An licensed Registered Nurse (RN) who is a self-employed provider;
- Licensed Home Health agencies; or
- Licensed In-Home agencies.

2. Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks.

Services include functional skills trainings, coaching, and prompting the individual to accomplish the ADL, IADL and health-related skills. Services will be specifically tied to the functional needs assessment and person-centered service plan and are a means to increase independence, preserve functioning, and reduce dependency of the service recipient.

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A worker may provide training and maintenance activities under the following conditions:

- The need for skill training or maintenance activities has been determined through the assessment process and has been authorized as part of the individual service plan;
- The activities are for the sole benefit of the individual and are only provided to the individual receiving CFC services;
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the person has a progressive medical condition;
- The activities are provided consistent with the stated preferences and outcomes in the individual support plan;
- The activities are provided concurrent with the performance of ADL, IADL, and health related tasks as described in the earlier section;
- Training and skill maintenance activities that involve the management of behavior during the training of skills, must use positive reinforcement techniques; and
- The provider must receive training about appropriate techniques for skill training and maintenance activities.

Skill training and maintenance activities do not include therapy (e.g., occupational, physical, communication therapy) or nursing services that must be performed by a licensed therapist or nurse, but may be used to complement therapy or nursing goals when authorized and coordinated through the person-centered service plan.

The majority of these services will be provided by state authorized skills trainers or programs who have demonstrated expertise in assisting individuals in the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living and instrumental activities of daily living.

Long-term Care Community Nursing Services are also in this category of services. LTCCNS nurses, within the scope of the state's nurse practice act requirements, assist individuals in the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish health related tasks. Community nurses are licensed registered nurses with the expertise to provide these skills.

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Coverage will be limited to devices and technology not covered by other Medicaid programs and will be limited to the least costly option necessary to meet the service recipient's assessed need. Electronic back-up systems are not available to individuals living in settings that are required to provide these back- up systems for their residents as part of licensing requirements. Technology will be provided by Medicaid enrolled provider or the state's approved purchasing guideline.

Relief Care:

Person-centered plan coordinators assist with identifying a regularly-scheduled relief care provider as part of the service plan or have identified back-up providers or care setting alternatives as part of the PCSP in case the participant's primary provider becomes ill or is suddenly no longer available. Additionally, individuals may utilize alternate service providers such as contracted in-home care agencies that can be employed on short notice if an individual cannot locate a Homecare Worker or Personal Support Worker who can meet their needs. Other licensed community-based service providers may be used to meet immediate care needs when an individual is unable to find a suitable provider to employ directly. Individuals can utilize 24 hour, home and community-based settings (such as FH/AFH/ALF/RCF/GCH, etc.) if they are unable to locate an in-home provider to meet immediate care needs. Local, state or contracted case management entities have access to Medicaid approved provider information for the state to assist individuals in selecting a provider from anywhere in the state.

Positive Behavioral Support Services:

Positive Behavioral Support Services are provided to assist individuals with behavioral challenges due to their disability, that prevent them from accomplishing ADL's, IADL's , and health related tasks. Positive Behavioral Support Services include coaching and support of positive behaviors, behavior modification and intervention supports to allow individuals to develop, maintain and/or enhance skills to accomplish ADL's, IADLs and health related tasks. The need for these services is determined through a functional needs assessment and the individual's goals as identified in the person centered planning process. Positive Behavioral Support Services may also include consultation to the care provider on how to mitigate behavior that may place the individual's health and safety at risk and prevent institutionalization.

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Services may be implemented in the home and/or community, based on an individual's assessed needs. All activities must be for the direct benefit of the Medicaid beneficiary.

Behavior Professionals will work with the individual and, if applicable, the caregiver, to assess the environmental, social, and interpersonal factors influencing the person's behaviors. The consultants will develop, in collaboration with the individual and if applicable, caregivers, a specific positive behavioral support plan to address the needs of the person to acquire, maintain and enhance skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living and health related tasks. These services do not include rehabilitation or treatment of mental health conditions. The provision of this service will not supplant the provision of personal attendant services that are based on the individual's assessed needs that are identified in the PCSP. Positive Behavioral Support Services are prior authorized based on the approved PCSP. Services are provided through Behavior Professionals approved by the Department or designee.

4. Voluntary training on how to select, manage, and dismiss attendants. Please identify who is performing these activities.

Individuals will be offered the opportunity to participate in training on how to manage their attendant services. As an example, the Oregon Home Care Commission (HCC) provides a voluntary training called the STEPS program that promotes successful working relationships between consumer-employers and homecare workers or Personal Support Workers. STEPS is a voluntary program offered statewide through the local Centers for Independent Living, Area Agencies on Aging or other not-for-profit organizations with the expertise to train eligible individuals. Individuals are informed of the training during service planning and are provided with information about the local contractor in order to register. The HCC also contacts individuals directly to offer the voluntary training.

All individuals will be offered the opportunity to participate in the training. The training will be offered on either a one-on-one basis or in a group format, depending on which format will meet the needs of the particular eligible individual. The training program will cover selection, management and dismissal of homecare workers and personal support workers.

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Topics will be specific to the individual but include: understanding the Person-centered Service Plan and Task List/Service Agreement, creating job descriptions, locating employees, interviewing and completing reference checks, training, supervising and communicating effectively with employees, tracking authorized hours worked, recognizing, discussing and attempting to correct any employee performance deficiencies, discharging unsatisfactory workers, and developing a back-up plan for coverage of services.

5. Support System Activities

The local, state or contracted case management entities, primarily through person-centered plan coordinators and state trained assessors, provide support system activities to individuals enrolled in CFC option. The activities provided by these entities include:

Assessment and counseling prior to enrollment in CFCO:

i. Information, counseling, training and assistance to ensure that an individual is able to manage the services.

ii. Information communicated to the individual in a manner and language understandable by the individual, including needed auxiliary aids and/or translation services.

iii. Support activities include the following:

i. Conducting person-centered planning
ii. Range and scope of available choices and options
iii. Process for changing the person-centered service plan
iv. Grievance process
v. Risks and responsibilities of self-direction.
vi. Free Choice of Providers
vii. Individual rights and appeal rights.
viii. Reassessment and review schedules
ix. Defining goals needs and preferences
x. Identifying and accessing services, supports and resources.

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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 other interactive methods, examples include but are not limited to, email or other secure methods, depending on the individual's preference and abilities.

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 individuals 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 setting where residential providers must provide meals. Home and community based 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 home and 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. This requirement does not require that caregivers that were previously unpaid should become paid caregivers under the CFC benefit, nor does this require that caregivers need to be paid beyond the paid hours authorized in the plan.) 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, personal emergency response systems, relief care providers, and environmental accessibility adaptations will not be allowed when they would duplicate other services provided under another benefit or program. Home and community based residential providers must ensure their residents have access to substantially similar services as those living in their own homes. Department contracted Community Nurses will provide services for individuals living in their own homes or Foster Homes. Payment for LTCCNS will not be allowed when individuals are receiving CFC services in other residential home and community based settings.

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

They will be allowed to have anyone they would like participate in the assessment process. Person-centered plan coordinators will also discuss psycho-social elements and the availability of natural supports to assist in meeting needs. The Department uses assessment tools that measure individual needs surrounding ADLs and IADLs along with cognitive/behavior concerns. The assessment records individual needs and preferences regarding the individual's choice of how the services are to be provided, regardless of what funding mechanisms or supports are intended to meet the individual's needs.

All level of care assessments and reevaluations are conducted by person-centered plan coordinators or state trained assessors. DHS' minimum person-centered plan coordinators qualifications and state trained assessors' qualifications are:

- Bachelor's degree in a Behavioral Science, Social Science, or a closely related field; OR
- Bachelor's degree in any field and one year of human services related experience (i.e., work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house); OR
- Associate's degree in a Behavioral Science, Social Science or a closely related field AND two years of human services related experience (i.e. work providing assistance to individuals and groups with issues such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate housing); OR
- Three years of human services related experience (i.e., work providing assistance to individuals and groups with issues such as economically disadvantaged , employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate housing);
- In addition to the above, state trained assessors responsible for completing assessments must meet initial and ongoing training requirements provided by DHS.

To meet Nursing Facility LOC, individuals must be assessed as meeting at least one of the following priority levels as defined in OAR 411-015-0010 to meet the nursing facility level of care criteria:

(1) Requires Full Assistance in Mobility, Eating, Elimination, and Cognition.

(2) Requires Full Assistance in Mobility, Eating, and Cognition.

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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. State trained assessors complete the initial LOC assessment. State trained assessors or person centered plan coordinators review the level of care annually, or more frequently based on the functional needs of the individual, or at the request of the eligible individual. The assessments happen during a face-to-face meeting with the individual. The state trained assessor or 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 state trained assessor 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 of a person with an intellectual disability or a closely related condition as well as functional impairments as a result of the condition.
The determination is based on the diagnosis and functional impairments (whether the individual has substantial limitations in the six areas of major life activity identified by CMS in the definition of persons with related conditions in 42 CFR §435.1010 (self-care; understanding and use of language; learning; mobility; self-direction; and capacity for independent living".

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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.

All individuals considered for the Hospital Level of Care are assessed using the Level of Care assessment form and MFCU clinical criteria. The MFCU Clinical Criteria combined with the Level of Care Assessment Form are the complete level of care evaluation. 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.

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.) This requirement does not require that caregivers that were previously unpaid should become paid caregivers under the CFC benefit, nor does this require that caregivers need to be paid beyond the paid hours authorized in the plan.

(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 PCSP and provide the participant a copy of the 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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The person-centered plan coordinator will consult with service providers and the individual throughout the assessment process to review and verify the appropriate services are being offered, performed and are still appropriate for the individual. This ongoing dialogue will ensure that any changes in condition or service choice allow for the assessment to be reviewed for appropriateness as quickly as possible. Local, state or contracted case management entities inform participants/ representatives about service options at changes in conditions and when the participant is transitioning from one care-setting to another.

Local, state or contracted case management entities assist with health care coordination and may make referrals to contracted LTCCNS Nurses, including delegation of some nursing tasks and teaching, training and monitoring on a variety of health-related topics. These services are provided to individuals in their own home or foster homes. All other licensed providers must have nursing staff available for delegation, teaching and training.

Each plan will address the eligible individual's choice for the type of services they receive, the service provider and location of the service delivery. Choice is a critical aspect in the person-centered service plan.

Each plan includes the type of service to be provided, the amount, frequency and duration of each service, and the type of provider to furnish each service. Since the plan is built in conjunction with the assessment of needs, it may be developed simultaneously with determination of level of care and eligibility for CFC services or shortly after, allowing time for researching and reviewing available natural supports, providers and service options.

An in-home service plan is implemented when a qualified provider is identified, the qualified provider's service start date is set and the authorized hours of services are determined. A plan for facility services is implemented as soon as the individual chooses and moves into a community-based facility. The individual has the right to request changes in qualified provider and living situation. A change in plan will be implemented as soon as an alternate plan can be developed. Person-centered plan coordinators will meet with the individual (and family or representative, as appropriate) at least annually to review and update the PCSP.

Local, state or contracted case management entities coordinate services for participants who reside in facilities in cooperation with facility staff at the direction of the individual. The person-centered plan coordinator communicates with facility staff on a regular basis and may participate in facility care conferences. These care conferences are distinct from the functional assessment, person-centered plan development process and other direct communication with the individual and their representative.

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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: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCBS/Pages/Transition-Plan.aspx

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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, Office of Developmental Disabilities Services (ODDS) or Child

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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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- **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 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.

3. 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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Standards for service delivery models for:

Training

Each provider type has specific training requirements described in Oregon Administrative Rule, as listed in the provider qualifications. Provider training may be provided by DHS, professional associations and independent trainers. Trainings are targeted to individuals, to specific provider types and delivery systems to ensure that the special needs of any particular population are addressed effectively. Person-centered plan coordinators receive training that includes formal training curriculum on person centered planning and philosophy and other critical case management activities. Person-centered plan coordinators and state trained assessors receive initial and ongoing training. Training includes working with consumers, eligibility, how to lead a functional needs assessment with the consumer, person-centered planning, choice counseling to ensure free choice of providers and service settings, service options and delivery systems, protective services, addressing needs of special populations.

Denials and Reconsiderations

DHS has standardized forms and processes for informing individuals/ representatives of rights, recording hearing requests, completing pre-hearing summaries, conducting hearings, and notifying individuals/representatives of the hearing outcomes.

DHS communicates additions or revisions to forms and processes to local, state or contracted case management entities through formal electronic transmittals.

Individual service recipients and applicants, and their representatives, are provided timely written notice of any planned change in services or benefits, including denial, closure or reduction. For denials, the time frame is 45 days from the date of application. For closure or reduction of benefits or services the time frame is 10 working days prior to the effective date of the proposed action. The notice includes the reason for DHS' decision, administrative rules that support the decision and the individual's/representative's right to due process through an administrative hearing process.

Appeals

The local, state or contracted case management entity notifies the individual about the Fair Hearing process during the initial assessment/service planning. As part of the notification of Fair Hearings procedure, the person-centered plan coordinator informs the individual that continuation of services must be requested by the individual under the timeframes specified in OAR.

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Results of the hearing are provided to the individual in the form of a Hearing Order written by the Administrative Law Judge. The Hearing Order is mailed to the individual.

Describe the quality assurance system's methods that maximize consumer independence and control and provide information about the provisions of quality improvement and assurance to each individual receiving such services and supports.

Local, state or contracted case management entities fully inform individuals of all available choices and service options. Documentation requirements and automated systems support quality assurance efforts. The QA processes defined above includes ensuring that individuals were fully informed of their options and their ability to direct their own service plan. This is monitored by eligible individual satisfaction surveys. QA teams meet with individuals receiving services in each local office audit to ensure eligible individual choice was offered and honored.

Describe how the State will elicit feedback from key stakeholders to improve the quality of the community-based attendant services and supports benefit.

The Department has established Development and Implementation Council, the majority of which is comprised of individuals with disabilities, elderly individuals and their representatives. The Department consults and collaborates with the Council on a regular basis to inform and elicit feedback regarding the services and supports provided to individuals receiving CFC services.

The methods used to continuously monitor the health and welfare of Community First Choice individuals

local, state or contracted case management entities regularly monitor service plans to ensure the health and welfare of individuals receiving CFC services. Through the use of risk management agreements, a monitoring plan is developed with the individual to review services and supports. Individuals receiving CFC services are informed of their right to request a review of their PCSP to ensure that their health and safety needs are being met through their self-directed service plan.

Abuse investigation services, as described above, are also a means of monitoring the health and welfare of CFC individuals.

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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 PCSP 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.

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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. 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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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.

Long-term Care Community Nursing Services Registered Nurses- LTCCNS 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 LTCCNS RN will request prior-authorization and submit claims for client services utilizing billing codes per instructions in the LTCCNS 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 PCSP 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 PCSP, 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 PCSP 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.