

Application for

Section 1915(b) (4) Waiver

Fee-for-Service

Selective Contracting Program

June 26, 2013

v1.0

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**Application for Section 1915(b) (4) Waiver
Fee-for-Service (FFS) Selective Contracting Program**

Facesheet

The **State** of **OregonOregon** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is **APD Case Management Freedom of Choice Waiver****APD Case Management Freedom of Choice Waiver**.

(List each program name if the waiver authorizes more than one program.)

Type of request. This is:

- an initial request for new waiver. All sections are filled.
 a request to amend an existing waiver, which modifies Section/Part _____
 a renewal request

Section **A** is:

- replaced in full
 carried over with no changes
 changes noted in **BOLD**.

Section **B** is:

- replaced in full
 changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of 5 5 years beginning July 1, 2013July 1, 2013 and ending June 30, 2018June 30, 2018.

Oregon is requesting a 5 year period for this waiver as authorized under § 2601 of the Affordable Care Act and supported with implementation guidance released in SMDL# 10-022 (5-Year Approval or Renewal Period for Certain Medicaid Waivers).

State Contact: The State contact person for this waiver is Jesse Anderson and can be reached by telephone at (503) 945-6958, or fax at, or e-mail at Jesse.Anderson@state.or.us. (List for each program)

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:

Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal (if additional space is needed, please supplement your answer with a Word attachment).

The Oregon Health Authority (OHA) has regular quarterly meetings with the nine federally recognized Tribes, Urban Indian Programs and Indian Health Service (IHS) representatives. The agendas are mainly driven by the Indian communities of Oregon, Urban Indian Programs and Indian Health Service (IHS) representatives and are constructed by requesting topics to be discussed at the meeting. The OHA may engage the tribal and urban program representatives outside of the meeting setting through correspondence in the event a policy change is needed more quickly than the next meeting will support. Each Tribe and Indian Organization selects its representative to the meetings based on whom the Tribe or Indian Organization feels is best to represent their needs.

The OHA discusses proposed State Plan Amendments, waiver proposals or amendments, demonstration project proposals or amendments, and rule-making that may have a direct impact on American Indians, Tribal entities, Urban Indian programs, or IHS. Additionally, items that impact eligibility, reduce payment rates, change payment methodologies, reduce covered services, or alter provider qualifications/requirements are discussed.

Process:

The normal process is to distribute documents describing a subject modification (30) days prior to any formal submission to the Centers for Medicare and Medicaid Services (CMS). These items then are discussed in a scheduled quarterly meeting. The materials are distributed through the Tribal Liaison to the nine federally recognized Tribes, Tribal Urban Indian programs and Indian Health Service (IHS) representatives.

The OHA may also utilize an expedited process in the event a deadline is outside the control of the State, or in severely time limited situations. The expedited process includes at a minimum, 10 days in advance of the change, the State provides written notification with the proposed change; anticipated impact; method for providing comments/questions; timeframe for feedback; and an opportunity for a face-to-face meeting or conference call if requested.

Oregon submitted the notice as outlined in the expedited process on April 1, 2013, prior to our submission of this application. Oregon received no feedback from the initial tribal notification. An amended notification will be submitted the week of May 27, 2013 to reflect changes that have been made. Oregon will be working with the tribes regarding any concerns they have throughout the approval process. The State does not feel the proposed change will have a negative impact on the Tribes, nor on any tribal members. The changes we are proposing are administrative in nature.

Program Description:

Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver (if additional space is needed, please supplement your answer with a Word attachment).

Through selective contracting, Oregon will be able to provide Case Management services as a 1915 (c) Waivered service through the existing service delivery model for Aged and Physically Disabled individuals. These services will be authorized through the Oregon APD 1915 (c) Waiver and delivered through the local Area Agencies on Aging (AAAs), and when not available in a service area, the Department of Human Services, Aged & Physically Disabled (APD) offices. Case Management services offered under the waiver will ensure the special income group requiring a waived service maintain eligibility, while receiving home and community based care services under the 1915 (k) Option. The AAAs and APD offices provide Medicaid eligibility, as well as Case Management. The use of AAAs to provide eligibility and case management services has been part of Oregon's Medicaid delivery system since 1981, when legislation was passed in an effort to provide services to individuals with as few barriers as possible. In Oregon, this meant combining the eligibility and case management of Medicaid services with Older Americans Act services whenever possible. The use of exclusive contracting will make uniform case management services possible across the state and accessible to all individuals eligible for services. Waiver Case Management is services furnished to assist individuals in gaining access to needed medical, social, educational and other services. Waiver Case Management includes the following assistance:

- Assessment and periodic reassessment of individual needs. These annual assessment (more frequent with significant change in condition) activities include:
 - Taking client history;
 - Evaluation of the extent and nature of recipient's needs (medical, social, educational, and other services) and completing related documentation;
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

- Development (and periodic revision) of a specific care plan that:
 - is based on the information collected through the assessment;
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities: To help an eligible individual obtain needed services including activities that help link and individual with:

- Medical, social, educational providers; or
 - Other programs and services capable of providing needed services to address identified needs and achieve goals specified in the care plan such as making referrals to providers for needed services, and scheduling appointments for the individual.
- **Monitoring and follow-up activities:** Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. The activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

Waiver case management may include contact with non-eligible individuals, that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Providers maintain case records that document for all individuals receiving case management as follows:

- i. The name of the individual;
- ii. The dates of the case management services;
- iii. The name of the provider agency (if relevant) and the person providing the case management service;
- iv. The nature and content of the case management services received and whether goals specified in the care plan have been achieved;
- v. Whether the individual has declined services in the care plan;
- vi. The need for, and occurrences of, coordination with other case managers;
- vii. A timeline for obtaining needed services;
- viii. A timeline for reevaluation of the plan.

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM 4302.F)).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)). All costs are consistent with the State's approved cost allocation plan and are in compliance with 2 CFR Part 225.

By utilizing the current provider network, Oregon is assuring that clients' case management services are coordinated and seamless with other services offered under the various Medicaid authorities.

Oregon agrees to comply with the special terms and conditions (STCs) attached to this waiver to ensure compliance with statutory and regulatory compliance.

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver (if additional space is needed, please supplement your answer with a Word attachment).

The State will not be offering any State Plan Services through this selective contracting waiver. Oregon will be combining a 1915 (c) Waiver with this 1915 (b) Waiver to provide Case Management as a selective contracting service.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

1915(b) (4) - FFS Selective Contracting program

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

a. **Section 1902(a) (1) - Statewideness**

b. **Section 1902(a) (10) (B) - Comparability of Services**

c. **Section 1902(a) (23) - Freedom of Choice**

d. **Other Sections of 1902 – (please specify)**

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

the same as stipulated in the State Plan

is different than stipulated in the State Plan (please describe)

Oregon will be using a rate methodology that differs from the approved state plan. Oregon will be using a monthly rate methodology.

The interim monthly rate is established biennially based on the results of a workload study and model that averages the monthly cost per individual served using the average annual time for case management services per individual enrolled in the waiver and the cost to provide those

services. The model uses the cost of case managers as the sum of the case manager’s compensation expense, direct supervisory compensation expense, direct supportive activities and indirect administrative cost of the provider organization related to case management activities. The total cost of case management is divided by the number of waiver enrollees and divided, again, by 24 to arrive at the interim monthly rate.

Payment of the full monthly rate will be paid retrospectively for each individual enrolled in the waiver during that month upon receipt of a claim for a qualifying activity. Payment is not guaranteed. Providers will be responsible for providing as much case management services as each person enrolled needs within a month, irrespective of the cost of providing those services.

Case management rates will be established at the beginning of each state biennium period using this same methodology. All costs are consistent with the State’s approved cost allocation plan and are in compliance with 2 CFR Part 225. Adjustments may be made to the rate periodically during the biennium if it is determined that the established rate is materially different than the cost of providing services.

On a biennial basis, State of Oregon revenue will be reconciled to actual cost with adjustments made to either increase the State’s claim to cost or refund any revenue above cost.

On a biennial basis, payments to AAAs will be reviewed against the cost of providing services to ensure actual costs incurred do not exceed revenues. Excess payments, if any, will be recovered from AAA providers and claiming to CMS will be decreased.

Waiver Year	Average Cost / Unit/ Resulting Interim Rate
July 1, 2013-June 30, 2014	\$168.19
July 1, 2014-June 30, 2015	\$168.19
July 1, 2015-June 30, 2016	\$175.76
July 1, 2016-June 30, 2017	\$175.76
July 1, 2017-June 30, 2018	\$183.67

2. **Procurement.** The State will select the contractor in the following manner:

- Competitive procurement
- Open cooperative procurement
- Sole source procurement
- Other (please describe)

Oregon will be contracting with AAAs to provide Case Management Services. When no AAA is available to contract with, the Oregon Department of Human Services will provide the services. This is consistent with the Oregon’s long-standing history and legislative intent surrounding services offered through the AAAs. In 1981 Oregon legislative session passed statute which established the system requiring Medicaid services for individuals aged 60 and

older to be delivered through AAAs. This service delivery model was later modified to include people with physical disabilities. AAAs have the right of refusal. When that occurs, the Oregon Department of Human Services conducts the eligibility and case management activities.

C. Restriction of Freedom of Choice

1. Provider Limitations.

Beneficiaries will be limited to a single provider in their service area.

Beneficiaries will be given a choice of providers in their service area.

(NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

Oregon will implement this new waiver service state-wide.

2. State Standards.

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents (if additional space is needed, please supplement your answer with a Word attachment).

There will be no change to the state standards detailed in the previously approved APD Waiver (0185). All providers must meet, accept and comply with the State's standards for reimbursement, quality and utilization. Case Management is a service that assists participants in gaining access to needed waiver and state plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services. The provider shall not have a personal financial interest in the services provided to the participant. Duplicate payments will not be made for case management services to the same participant by more than one provider. Case managers shall initiate and oversee the process of assessment and reassessment of the participant's level of care. Local offices are responsible for ongoing monitoring of the provision of services included in the participant's person-centered plan. Case managers must have a minimum of three face-to-face contacts with the participant per year. The participant's annual reevaluation may be counted as one face-to-face contact. Case managers must understand, respect and maintain confidentiality in regard to all details of their work.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations.** The following populations are included in the waiver:

Section 1931 Children and Related Populations

Section 1931 Adults and Related Populations

Blind/Disabled Adults and Related Populations

Blind/Disabled Children and Related Populations

Aged and Related Populations

- Foster Care Children
- Title XXI CHIP Children

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

- Dual Eligibles
- Poverty Level Pregnant Women
- Individuals with other insurance
- Individuals residing in a nursing facility or ICF/MR
- Individuals enrolled in a managed care program
- Individuals participating in a HCBS Waiver program
- American Indians/Alaskan Natives
- Special Needs Children (State Defined). Please provide this definition.
Children will not be served through this waiver.
- Individuals receiving retroactive eligibility
- Other (Please define): [Click here to enter text.](#)

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.*, what constitutes timely access to the service?

Oregon Administrative Rules require that initial assessments and service plans are made within 45 days of the service request. The AAA contracts require that each individual who has been hospitalized receive a face-to-face assessment during the hospital, whenever possible. If not possible the assessment must be completed within 7 days of discharge.

Annually full reassessments are required in OAR 411-030-0050. Oregon will require, contractually and in administrative rule that in-person contact be made at least quarterly, with monitoring conducted at least monthly. The Department standard to reply to an inquiry from an individual or their representative is 1 business day.

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment)?

Oregon has standard, computer generated reports outlining any cases in which an individual did not receive their completed assessment and service plan within 45 days of request. These reports identify the service delivery area, office and worker assigned to the individual's case. There are reports identifying any reassessments not done timely.

Oregon's QA Team conducts random sample reviews of individual case records in all local APD and AAA offices on a two year cycle. Among the items that they investigate is timeliness, accuracy, program outcomes, compliance with federal and state regulations, consumer satisfaction, and appropriateness of services.

Additionally, local offices are required to complete a 1% random sampling review of participants in their office using a standard survey form. The form records review of actions taken involving documentation and timing of assessments and reassessments, eligibility, participant preferences, risk monitoring, participant goals, contingency plans, signed plan of care and participant choice form. Appropriateness and frequency of participant contacts with the case manager is also reviewed. The local office managers are responsible for reviewing each case, documenting corrective actions and signing off on the review. The local office returns a finished survey form for each case reviewed to APD for evaluation, database entry, tracking and analysis. APD staff compile this information into reports at least annually and more frequently as needed by APD Management or the Quality Assurance Committee.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion (if additional space is needed, please supplement your answer with a Word attachment).

If it is found, during the QA review or the 1% internal sampling, that a service area provider has not been delivering timely services, a corrective action plan must be completed. The local office must submit a plan of correction to APD within 30 days of receipt of the QA report. APD then issues a final report to the local office. The QA Team revisits each office 90 days after the corrective action plan has been submitted to review for compliance with the corrective action plan. Every office has a review at least once every two years.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

Oregon has invested significant efforts in developing work-load models with-in the APD/AAA service delivery system to ensure adequate staffing is available to serve all individuals needing services. Waiver eligible individuals have access to case management services through 20 Area Agencies on Aging (AAA) and 33 Department of Human Services, APD offices providing case management services. Providers are required to ensure adequate capacity for case management services within their contract.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

Time studies have been conducted to determine the number of case managers needed across the state to ensure that all waiver eligible individuals can receive adequate and timely access

to case management services. This work-load model is quite easily adaptable to adjust to service needs growth. The time study was conducted categorizing the needed level of case management services based on whether an individual lives in their own home or individuals living in community based care settings.

The analysis shows individuals living in their own homes require 23.8 hours of case management service per year on average while individuals living in a community based care setting require 18.5 hours of case management service on average per year. The difference in the amount of case management used demonstrates Oregon's extensive effort to assist individuals to live in the least restrictive setting possible. Based on the current the time studies, the APD/AAA system currently requires 484 case managers to serve waiver eligible individuals. Allocation of case managers is conducted using local area waiver enrollee demographics.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program (if additional space is needed, please supplement your answer with a Word attachment).

Oregon has monthly case reporting down to the individual case manager level to ensure adequate capacity is available within each area of the state. Allocation of case management funding and staffing is conducted using local area waiver enrollee demographics. Local area management has control to ensure any single office or case manager is not over capacity. The local area management will adjust staffing for categories of individuals with heavy case management needs. Because of the variabilities that can occur from month to month. Trending of this data is commonly used.

When a case manager reassignment is necessary, the local management team will determine which case manager will provide services to each specific individual. Letters are sent to the individuals describing the change. The newly assigned case manager will contact the individual to introduce themselves. Individuals will be able to choose a new case manager if there is a reason the assigned case manager is not acceptable. The local management will work with the individual to get a new case manager assigned.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

Due to the variability of case management needs from month-to-month, utilization standards will be reviewed on an annual basis. Each individual receiving services should have no fewer than one service assessment and service plan conducted per year. Dependent on an individual's unique needs, risk monitoring will be conducted annually at a minimum, and as frequently as monthly. Complete service plan reviews will be conducted no fewer than three times per year, per enrollee.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined

by the utilization standard described above (if additional space is needed, please supplement your answer with a Word attachment)?

The State monitors the program through a number of mechanisms. The Department will be performing utilization reviews on a monthly basis. Such reviews shall consider variables in utilization for consumer directed services provided through the Independent Choices Program (State Plan J Option), for individuals receiving services in their own homes, and for individuals receiving community based care services.

The Department will monitor assessment, service planning and risk assessment and mitigation activities through reports. The Department will conduct random moment sampling to review utilization of case management and support activities.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above (if additional space is needed, please supplement your answer with a Word attachment).

Local office management will have monthly reports of individuals not receiving case management services so that a monitoring activity can occur. If an individual is not receiving the expected level of service efforts will be made to initiate contact. At this point individuals will either receive a phone call, a personal visit or the case management staff will contact the individual's family or caregiver to ensure the service needs are being met.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).
 - a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):
 - i Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.
 - ii Take(s) corrective action if there is a failure to comply.
2. Describe the State's contract monitoring process specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).
 - a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):
 - i Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

ii Take(s) corrective action if there is a failure to comply.

The Department has undergone extensive review of its quality measures over the past two years. Specifically, the Department is measuring the following quality standards:

- Number of race/ethnic groupings that are over/under represented in comparison to their representation in the population as a whole.
- Percent of spending plans within target.
- Percent of counties that have direct staff that are 95% representative of the population they serve.
- Average length of time for processing of service exception requests.

The state operates a quarterly business review process in which all of the above items bulleted standards are addressed. Each measurement has a status range for on target (green), improvement needed (yellow), unacceptable (red). Trending is tracked as well as whether target has been reached in each area. This quarterly business review allows for management to have a visual of areas that might be slipping and areas in which success is being achieved. By having the reviews on a quarterly schedule, the Department is well-positioned to respond to areas of concern and implement necessary changes or develop corrective action plans as necessary.

The State's primary means of ensuring compliance with the AAA's and the APD operated service delivery areas is through corrective action plans. Corrective action plans are a formal process in which status updates are required until the AAA or APD office comes into compliance with quality standards. The Department has the ability to modify the contract with the AAA to remove Medicaid functions, including case management services, if the non-compliance issues are egregious or long-standing.

The monitoring process for AAA contracts and APD operated service delivery compliance involves QA field reviews every two years and internal 1% sampling annually, as described in Part II. A. 1.; quarterly review of the quality measures and standardized utilization reports, as described in this section; surveys of service recipients; and, analyses of Fair Hearings data. Surveys are conducted annually with a random sampling of individuals being contacted for input. Fair Hearings data is kept on a continual basis with reports generated detailing specific nature of the requests, dates of action and disposition statuses of the hearings. This allows for trends to be monitored and issues that may require policy guidance or training to be addressed. The QA field reviews are conducted by staff from the Office of Payment Accuracy and Recovery (OPAR). OPAR is an independent office of the Department serving both DHS and the Oregon Health Authority by providing program integrity and auditing services.

In the instance that an AAA has lost its certification to provide Medicaid functions, individuals in that service area are initially informed with a letter and then receive follow up interaction with direct contact from state staff. Initial reassignments to new case managers are conducted randomly. Individuals are allowed to change case managers at any point.

If an AAA has previously lost their contract to provide Medicaid functions and want to provide those functions again, the formal certification process would need to be reinitiated. This process entails the following:

- a) The AAA notifies the Department in writing of its interest in changing its AAA designation to include Medicaid functions.
- b) The Department informs the Governor's Commission on Senior Services, the Oregon Disabilities Commission, the local Disability Services Advisory Council, and the local Senior Advisory Council and provides opportunity for local input.
- c) The AAA is required to provide notice to affected populations and constituencies at the local level of its intent.
- d) The AAA must provide, to the Department, sufficient information regarding:
 - a. Staffing plans (capacity and qualifications)
 - b. Fiscal soundness (start-up costs, a detailed budget for the first year of operations, written financial policies, and cost allocation policies)
 - c. Board oversight
 - d. Advisory Council involvement
 - e. Policy & procedure development and implementation
 - f. Management controls including program oversight and coordination, audited financial reports, and independent compliance reviews.
- e) The AAA must involve affected stakeholders in the development of a process that includes identifying any issues of concern, a process to address these concerns, and the development of a service delivery plan.
- f) The AAA must hold public hearings within the local area during the planning process to receive comments and recommendations on the issues of concern and the service plan.
- g) The Senior Advisory Council and Disability Services Advisory Council must certify in writing that they have been involved in developing the plan.
- h) The AAA must submit the service delivery plan to the Department.
- i) Once the plan has been approved by the Department, the AAA will work closely with the Department to ensure compliance in all areas.
- j) The AAA must complete 1% sampling on a six month rotation and the QA Field Review will be required. This level of monitoring will be required for a minimum of 3 years.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

Oregon administers most of the health and human services for the aging and people with disabilities populations through its AAA contracts and local DHS offices. These services include:

- Medicaid eligibility
- Older Americans Act programs
- Supplemental Nutritional Assistance Program
- Adult Protective Services
- home-care worker approval
- community based care residential setting licensure
- §1915(c) waiver eligibility determinations, level of care evaluations, needs assessments, service planning, authorization of services and monitoring of service delivery and plans.

Oregon established this coordinated effort in the early 1980s. Restricting case management to the existing service delivery model utilizes the existing knowledge of local resources, geographic

proximity of local case managers to the individuals receiving services, and the continuity of a single organization coordinating all services and responsible for all aspects of the administrative functions, which are often co-dependent with waiver case management services. Universally used computer systems in the existing service delivery model ensure that all staff are accessing the same information, without delays in data transfer. This is possible because of the limitation in providers of case management services to our existing state and AAA staff. Separating the functions between other provider types would add administrative cost and cause delays in service delivery for individuals receiving services. Selective contracting for these services increases the quality care to individuals receiving services.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

Waiver enrollees will receive information about the selective contracting program when they are screened for services and when they receive an assessment or reassessment for long-term care services.

B. Individuals with Special Needs

- The State has special processes in place for persons with special needs
(Please provide detail).

Individuals who are enrolled in this waiver program all have special needs. A person-centered plan is a requirement of case management services for all individuals receiving services under this waiver and under the § 1915 (c) service that runs concurrent with this waiver. Each plan lists services that are needed to meet the individual's unique needs.

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State’s efficient and economic provision of covered care and services (if additional space is needed, please supplement your answer with a Word attachment).

By utilizing a single entity in a service area duplication is minimized and communication is streamlined. When one agency is responsible for all aspects of case management for multiple programs information services are able to be consolidated, administrative services are able to be streamlined, and coordination of services is more efficient. By using the existing service delivery structure, the impact of changes is significantly reduced.

2. Project the waiver expenditures for the upcoming waiver period.

All amounts listed are using Total Fund Expenditure projections.

Year 1 from: 7/1/2013 to 6/30/2014

Trend rate from current expenditures (or historical figures): NA%

Projected pre-waiver cost	<u>\$47,100,000</u>
Projected Waiver cost	<u>\$47,100,000</u>
Difference:	<u>NA</u>

Year 2 from: 7 / 1 / 2014 to 6 / 30 / 2015

Trend rate from current expenditures (or historical figures): NA %

Projected pre-waiver cost	<u>\$47,100,000</u>
Projected Waiver cost	<u>\$47,100,000</u>
Difference:	<u>NA</u>

Year 3 (if applicable) from: 7 / 1 / 2015 to 6 / 30 / 2016

(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost	<u>NA \$49,200,000</u>
Projected Waiver cost	<u>\$49,200,000</u>
Difference:	<u>NA</u>

Year 4 (if applicable) from: 7 / 1 / 2016 to 6 / 30 / 2017

(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost	<u>\$49,200,000</u>	Projected Waiver cost	<u>\$49,200,000</u>
Difference:	<u>NA</u>		

Year 5 (if applicable) from: 7 / 1 / 2017 to 6 / 30 / 2018

(For renewals, use trend rate from previous year and claims data from the CMS-64)

Projected pre-waiver cost	<u>NA \$51,400,000</u>
Projected Waiver cost	<u>\$51,400,000</u>
Difference:	<u>NA</u>