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State/Territory Name: Oregon

State Plan Amendment (SPA) #: 16-0007

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

December 21, 2016

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

RE: Oregon State Plan Amendment (SPA) Transmittal Number 16-0007

Dear Ms. Saxton:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA) Transmittal Number 16-0007. This SPA renews Oregon's 1915(i) State Plan Home and Community-Based Services (HCBS) benefit for individuals with chronic mental illness.

The SPA is approved with an effective date of January 1, 2017 and an expiration date of December 31, 2021. Since the state has elected to target the population who can receive Section 1915(i) State Plan HCBS, CMS approves this SPA for a five-year period, in accordance with Section 1915(i)(7) of the Act. To renew the 1915(i) State Plan HCBS benefit for an additional five-year period, the state must provide a written request for renewal to CMS at least 180 days prior to the end of the approval period. CMS approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the 1915(i) state plan HCBS in the previous year. Additionally, at least 18 months prior to the end of the five-year approval period, the state must submit to CMS a report with the results of the state's quality monitoring, including an analysis of state data, findings, any remediation, and systems improvement for each of the 1915(i) requirements in accordance with the Quality Improvement Strategy in their approved SPA. Submission of the report 18 months in advance of the end of the approval period will allow time for CMS to review, respond, and for the state to make any necessary changes as a result prior to the state's submission of a renewal request to CMS.

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

Sincerely,

Digitally signed by David L. Meacham -S

[redacted]

David L. Meacham
Associate Regional Administrator

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **16-0007**

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
1/1/17

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(i) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2017 $ 41,311,000
b. FFY 2018 $ 42,385,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~Supplement 4 to Attachment 3.1 A, page 1-67 (P&I)~~~~page 1-71(P&I)~~
~~Supplement 4 to Attachment 3.1-A, page 1-42~~ ~~45~~(P&I)
Attachment 4.19-B, page 12-13
Supplement 4 to Attachment 3.1-A, page ~~1-74~~ (P&I) 1-72 (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Supplement 4 to Attachment 3.1-A, page 1-39
Attachment 4.19-B, page 12-13

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to renew the 1915(i) state plan.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME Lori Coyner, MA

14. TITLE: Medicaid Director, OHA

15. DATE SUBMITTED:

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

ATTN: Jesse Anderson, State Plan Manager

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 7/1/16

18. DATE APPROVED: 12/21/16

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/17

20. SIGNATURE OF REGIONAL OFFICIAL:
Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS, ou=CMS, ou=People, cn=David L. Meacham -S
Date: 2016.12.21 12:53:05 -08'00'
[redacted]

21. TYPED NAME: David L. Meacham

22. TITLE: Associate Regional Administrator

23. REMARKS:

7/1/16: State authorized P&I change to Box 8
10/13/16: State authorized P&I change to Box 8
11/23/16: State authorized P&I change to Box 8
12/12/16: State authorized P&I change to Box 8
12/14/16: State authorized P&I change to Box 8

§1915(i) HCBS State plan Services
State/Territory: Oregon

Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Home Based Habilitation, HCBS Behavioral Habilitation, HCBS psychosocial Rehabilitation for persons with CMI.

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*: ***Select one*:**

○	**Not applicable**
●	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act**. The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the1915(a) contract has been submitted or previously approved*
☐	**Waiver(s) authorized under §1915(b) of the Act**. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)

§1915(i) HCBS State plan Services
State/Territory: Oregon

☐	☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
	☑	**A program authorized under §1115 of the Act.** *Specify the program*:
		Oregon Health Plan

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

●	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	●	The Medical Assistance Unit *(name of unit)*:	Health Systems Division
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	
○	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

§1915(i) HCBS State plan Services
State/Territory: Oregon

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the State assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑	☑	☑	☐
3 Review of participant service plans	☑	☐	☑	☐
4 Prior authorization of State plan HCBS	☑	☐	☑	☐
5 Utilization management	☑	☐	☑	☐
6 Qualified provider enrollment	☑	☐	☐	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐	☑	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Other State Operating Agency is the Department of Human Service, Aging and People with Disabilities Division who determine non- MAGI Medicaid eligibility as a part of its operational function.

Contracted Entity is an Independent and Qualified Agent (IQA) that determines service eligibility, reviews participant service plans, prior authorizes HCBS services, conducts medical appropriateness review (utilization management) and Quality assurance and quality improvement activities. The IQA also performs need based assessment, performs transition management and planning for recipients denied continued stay in licensed levels of care.

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

6. ☑**Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑**No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	1/1/17	12/31/17	2000

2. ☑**Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

§1915(i) HCBS State plan Services
State/Territory: Oregon

Financial Eligibility

1. ☑ **Medicaid Eligible. .** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy.** *(Select one):*

☑ The State does not provide State plan HCBS to the medically needy.
☐ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, medically needy individuals receive only 1915(i) services. ☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

§1915(i) HCBS State plan Services
State/Territory: Oregon

Evaluation/Reevaluation of Eligibility

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

○	Directly by the Medicaid agency
●	By Other (*specify State agency or entity with contract with the State Medicaid agency*):
	Independent and Qualified Agent (IQA)

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications*

Needs based evaluations, person centered plans and medical appropriateness reviews are conducted by staff of the IQA who meet the requirements of a Qualified Mental Health Professional.

Qualifications for a **QMHP** are:

- Graduate degree in psychology; or
- Bachelor's degree in nursing and be licensed by the State of Oregon; or
- Graduate degree in social work; or
- Graduate degree in a behavioral science field; or
- Graduate degree in recreational, art, or music therapy; or
- Bachelor's degree in occupational therapy and be licensed by the State of Oregon; AND

Education and experience which demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multi-axial DSM diagnosis; write and supervise a treatment plan, conduct a comprehensive mental health assessment and provide individual, family, and/or group therapy within the scope of practice.

§1915(i) HCBS State plan Services
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3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The IQA receives requests for eligibility determinations for individuals who are potentially eligible for 1915(i) HCBS services from a referrer.

IQA conducts a face-to-face needs assessment with the individual the individuals authorized representative, if applicable, and in consultation with other persons identified by the individual, such as, but not limited to, the spouses, family, guardian, and treating and consulting health and support professionals responsible for the individuals care to determine if a recipient of 1915(i) HCBS services is eligible for the services based on the diagnostic and needs-based criteria defined in Oregon's 1915(i) State Plan Amendment.

The IQA's review of necessary information, conducting the face-to-face needs assessment, and consultation with the individual, individual's authorized representative, if applicable, and other persons identified by the individual result in the person-centered service plan.

As part of the person centered needs assessment process, OHA utilizes the Level of Care Utilization System (LOCUS) and the Level of Service Inquiry (LSI) are tools utilized as part of the overall package of information used (as described above) by the IQA to determine whether an individual meets the needs based criteria for 1915(i) services.

The IQA provides necessary information in plain language in a manner accessible to individuals with disabilities and persons whose English proficiency is limited. Cultural factors must be considered.

Reevaluations, using the methodology described above, are conducted no less frequently than annually, when an individual requests a reevaluation, or when the individual's needs have changed.

Process for Performing Evaluation/Reevaluation (Cont)

Medicaid financial eligibility determinations & redeterminations are conducted by DHS, APD. Eligibility determinations and redeterminations using needs-based criteria for 1915(i) HCBS are made by the IQA through review of all necessary clinical records.

4. ☑ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The person has a need for assistance in two areas of Instrumental Activities of Daily Living (IADL) due to the symptoms of a behavioral health condition. IADLs include, but are not limited to, housekeeping including laundry, shopping, transportation, medication management, and meal preparation. Assistance is defined as hands-on, supervision, and/or cueing.

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
The person has a need for assistance in two areas of Instrumental Activities of Daily Living (IADL) due to the symptoms of a behavioral health condition. IADLs include, but are not limited to, housekeeping including laundry, shopping, transportation, medication management, and meal preparation. Assistance is defined as hands-on, supervision, and/or cueing.	For adults served under the Aging and Physical Disabilities Waiver, which requires NF LOC, be assessed as meeting at least one of the following priority levels as defined in OAR 411-015-0010: (1) Requires Full Assistance in Mobility, Eating, Elimination, and Cognition. (2) Requires Full Assistance in Mobility, Eating, and Cognition. (3) Requires Full Assistance in Mobility, or Cognition, or Eating. (4) Requires Full Assistance in Elimination. (5) Requires Substantial Assistance with Mobility, Assistance with Elimination and Assistance with Eating.	1. The individual has a history of an intellectual disability or a developmental disability as defined below: "Developmental disability" means a disability that originates in childhood, that is likely to continue and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional. Developmental Disabilities include intellectual disability, autism, cerebral palsy, epilepsy, or other neurological disabling condition that require training or support similar to that required by individuals with mental retardation, and the disability:	**Criteria for Long Term Psychiatric Inpatient Care** • Primary DSM Diagnosis is severe psychiatric disorder; • Documented need for 24-hour hospital level medical supervision; and • At least one of the following conditions are met: o A need for extended (more than 21 days) regulation of Medications due to significant complications arising from severe side effects of Medications. o Need for continued treatment with electroconvulsive therapy where an extended (more than 21 days).

§1915(i) HCBS State plan Services
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Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
	(6) Requires Substantial Assistance with Mobility and Assistance with Eating. (7) Requires Substantial Assistance with Mobility and Assistance with Elimination. (8) Requires Minimal Assistance with Mobility and Assistance with Eating and Elimination. (9) Requires Assistance with Eating and Elimination. (10) Requires Substantial Assistance with Mobility. (11) Requires Minimal Assistance with Mobility and Assistance with Elimination. (12) Requires Minimal Assistance with Mobility and Assistance with Eating. (13) Requires Assistance with Elimination.	o Originates before the individual attains the age of 22 years, except that in the case of intellectual disability, the condition must be manifested before the age of 18; and Originates in and directly effects the brain and has continued, or can be expected to continue, indefinitely; and o Constitutes a significant impairment in adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080; and o The condition or impairment must not be primarily attributed to mental or emotional disorders, sensory impairments, substance abuse, personality disorder, learning disability or Attention Deficit Hyperactivity Disorder (ADHD). OAR 411-320-0020 or;	o Inpatient environment is indicated and the inappropriateness of a short-term or less restrictive treatment program is documented in the Clinical Record. o Continued actual danger to self, others or property that is manifested by at least one of the following: ▪ The OHP Member has continued to make suicide attempts or substantial (life-threatening) suicidal gestures or has expressed continuous and substantial suicidal planning or substantial ongoing threats. ▪ The OHP Member has continued to show evidence of danger to others as demonstrated by continued violent acts to person or imminent plans to harm another person.

*Long Term Care/Chronic Care Hospital

§1915(i) HCBS State plan Services
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Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
		"Intellectual Disability" significantly sub-average general intellectual functioning defined as full scale intelligence quotients (IQs) 70 and under as measured by a qualified professional and existing concurrently with significant impairment in adaptive behavior directly related to an intellectual disability as described in OAR 411-320-0080 that is manifested during the developmental period prior to 18 years of age. Individuals with a valid full scale IQ of 71-75 may be considered to have an intellectual disability if there is also significant impairment in adaptive behavior as diagnosed and measured by a licensed clinical or school psychologist as described in OAR 411-320-0080. AND 2. The individual has a significant impairment in one or more areas of adaptive behavior as defined in OAR 411-320-0020(3): (3) Adaptive Behavior" means the degree to which an individual meets the	▪ The OHP Member has continued to show evidence of severe inability to care for basic needs but has potential for significant improvement with treatment. ▪ Failure of intensive extended care services evidenced by documentation in the Clinical Record of: ➢ An intensification of symptoms and/or behavior management problems beyond the capacity of the extended care service to manage within its programs; and ➢ Multiple attempts to manage symptom intensification or behavior management problems within the local Acute Inpatient Hospital Psychiatric Care unit. ➢ Has received all Usual and Customary Treatment including, if Medically Appropriate, establishment of a Medication program and use of a Medication Override Procedure.

*Long Term Care/Chronic Care Hospital

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
		standards of personal independence and social responsibility expected for age and culture group. Other terms used to describe adaptive behavior include, but are not limited to, adaptive impairment, ability to function, daily living skills, and adaptive functioning. Adaptive behaviors are everyday living skills including, but not limited to, walking (mobility), talking (communication), getting dressed or toileting (self-care), going to school or work (community use), and making choices (self-direction). e) "Significant impairment" in adaptive behavior means: (A) A composite score of at least two standard deviations below the norm; (B) Two or more domain scores as identified in subsection (b) of this section are at least two standard deviations below the norm; or	

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
		(C) Two or more skilled areas as identified in subsection (d) of this section are at least two standard deviations below the norm.	

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Persons who are twenty one years of age or older with a chronic mental illness.

Person with a chronic mental illness means an individual who is diagnosed by a psychiatrist, a licensed clinical psychologist, a licensed independent practitioner as defined in ORS 426.005 or a nonmedical examiner certified by the Oregon Health Authority or the Department of Human Services as having chronic schizophrenia, a chronic major affective disorder, a chronic paranoid disorder or another chronic psychotic mental disorder other than those caused by substance abuse.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

8. ☑ **Adjustment Authority**. The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* 1	
ii.	**Frequency of services**. The state requires (select one):	
	●	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

   (Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

Oregon assures that the setting transition plan included with this 1915(i) State Plan Amendment will be subject to any provisions or requirements in the State's approved Statewide Transition Plan. The State will implement any applicable required changes upon approval of the Statewide Transition Plan and will make conforming changes to its 1915(i) State Plan Amendment, as needed, when it submits the next amendment or renewal. The most recent version of the Statewide Transition Plan can be found here: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCBS/Pages/index.aspx

The Oregon Health Authority (OHA) has submitted a Global Transition Plan (Transition Plan) in accordance with requirements set forth in the Centers for Medicare and Medicaid Services Home and Community Based Services (HCBS) Setting and Person Centered Planning Rule released on January 16, 2014. This Transition Plan includes programs and settings in which individuals receive Medicaid HCBS outside of their own or family home. Individuals enrolled in the 1915(i) Home and Community-based Services State Plan Option reside in their own or family homes or in licensed/certified settings of their choice.

Phase I. Initial Regulatory Assessment (June- 2014 – April 2015)
DHS and OHA have completed an initial assessment of Oregon Revised Statutes (ORS), Oregon Administrative Rules (OAR), policies and contracts to determine regulatory compliance with the new Code of Federal Regulations across three service delivery systems; OHA's Health Systems Division, formerly known as and referred to in this Transition Plan as Addictions and Mental Health (AMH), Aging and People with Disabilities (APD), and Office of Developmental Disabilities Services (ODDS). In general, DHS's and OHA's initial assessment has led to the conclusion that ORSs, OARs, policies, and contracts are in compliance with the HCBS regulations.

Areas that need to be addressed are identified below. However, key activities in the Transition Plan will further assess compliance and remediate any remaining areas of concern.

The initial assessment of ORSs, OARs, policies, and contracts specific to provider-owned, controlled, or operated residential HCBS settings was completed on August 4, 2014. The three service delivery systems reviewed ORSs 409, 410, 413, 427, 430, and 443, OARs (see Appendix C), policies, and contracts.

This assessment led to the creation of a "global scorecard". The scorecard (Appendix B) evaluates rules and regulations related to provider-owned, controlled, or operated settings licensed/certified by APD, AMH and by DHS's Office of Licensing and Regulatory Oversight (OLRO) on behalf of APD and ODDS programs. These setting types include residential settings listed below and identified in Oregon's approved Medicaid State Plan Options and Waivers (see Appendix D).

An individual's own or family home is presumed to meet the qualities of a home and community-based setting per CMS guidance and are not provider-owned, controlled, or operated residential settings. Oregon provides services to individuals residing in their own or family homes through the 1915(k) Community First Choice State Plan Option and 1915(c) HCBS Waivers operated by APD and ODDS and the 1915(i) HCBS State Plan Option operated by OHA, HSD.

Upon release of CMS's guidance for non-residential settings, DHS and OHA completed the same initial regulatory assessment for certified and unlicensed settings, such as employment and adult day programs, providing HCBS to determine if the statutes, rules, policies and contracts for these settings are in compliance with the new regulations. The three service delivery systems reviewed pertinent ORSs, OARs (see Appendix A), policies, and contracts. The scorecard was updated with the results of this initial regulatory assessment of non-residential settings. The initial non-residential settings assessment was completed on January 22, 2015. The rules, policies, and contracts regulating services in non-residential employment and day service settings are in compliance.

The scorecard is not intended to be the final determination of current individual site compliance or identification of any necessary changes, but it provides an initial snapshot of the status of Oregon's HCBS system. Through this initial assessment, DHS and OHA have found that no immediate changes were necessary to its Oregon Revised Statues (ORS).

However, since submitting the initial Global Transition Plan on October 13, 2014, Oregon determined that changes are needed to OARs, not because of inherent areas of non-compliance, but to ensure clarity and facilitate initial and ongoing provider compliance.

Oregon has finalized an over-arching Oregon Administrative Rule that will govern HCBS setting requirements across the three delivery systems. That rule was effective January 1, 2016 as identified in the Global Transition Plan timeline. Each delivery system has amended specific program rules for full compliance with the over-arching OAR for all HCBS settings requirements and federal HCBS settings regulations.
Specific changes in policies, practices and contracts, and changes found necessary to 1915(c) waivers, and 1915(i) and 1915(k) State Plan Amendments will occur after the provider self-assessment and individual's experience assessment phase.
The global scorecard was separately shared with the Stakeholders at a meeting on August 5, 2014, updated, and posted on Oregon's HCBS website (HCBS website) on March 9, 2015. The global scorecard has been updated to include non-residential service settings. Oregon's HCBS website address http://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCBS/Pages/index.aspx. The global scorecard is also a component of the Transition Plan. As updates to the Transition Plan and global scorecard occur, the HCBS website is updated with current materials and information. This allows Stakeholders and the broader public the chance to provide feedback on the global scorecard as well as the Transition Plan. Individuals may obtain non-electronic copies of the global scorecard and Global Transition Plan by contacting their assigned person-centered service plan coordinator, local field office, or DHS and OHA Central Office staff. Additionally, information is provided regarding how to obtain non-electronic copies of the Global Transition Plan and global scorecard at community forums held by the State and training/technical assistance presentations provided by the State. Public insight and input, based on their individual experience, into the actual level of compliance is vital as DHS and OHA move towards full compliance.

During the initial regulatory assessments, DHS and OHA determined that Oregon's regulations met the following components of the HCBS requirements:

- The setting is selected by the individual, or their representative, from among all available options, including services and supports in the individual's home, unless there are legal impediments that prohibit the individual from being served in a particular setting.
- The setting choice is identified and documented in the person-centered service plan and are based on the individual's needs, and preferences.
- The delivery system facilitates individual choice regarding services and supports, and who provides them.

Through the assessment of statutes, rules, policies and contracts, DHS and OHA determined that regulations for most residential setting types meet the following components of the HCBS requirements:

- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
    - In limited circumstances, some individuals may need appropriate supports that include personal protective interventions. This is limited to individuals who are a danger to themselves or others and need emergency interventions to be protected.
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- The unit or dwelling can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, substantially similar responsibilities and protections from eviction.
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- The setting is physically accessible to the individual.

Based on the initial regulatory assessment and subsequent implementation of the overarching HCBS OAR and revised program-specific rules, OHA and DHS have determined that Oregon's regulations for its HCBS setting types currently fall into the HCBS regulations compliance category identified below:

Fully comply with the federal requirements:

- AMH Adult Foster Homes;
- AMH Non-Licensed Housing (non-provider owned, controlled or operated);
- AMH Residential Treatment Homes;
- AMH Residential Treatment Facilities;

AMH Licensed Sites and Capacity

	Adult Foster Homes	**Residential Treatment Homes**	**Residential Treatment Facilities**
# of Sites	138	60	47
Capacity (Beds)	665	341	675

Phase II. Statewide Training and Education Efforts (July- 2014 – March 2019)

Provider, Individual and Delivery System Education DHS and OHA will develop a variety of ways to educate Stakeholders and the broader public. These methods include the use of electronic media and community meetings. DHS and OHA have developed a website designed to provide information and provider training materials in order to keep the broader community informed about the transition progress. The HCBS website will also allow the broader community to have continuous input into the transition process.

Individual and Family Education (July 2014 – March 2019) In collaboration with Stakeholders, and based upon the results of compliance activities conducted by the agencies and their service delivery systems, DHS and OHA will develop educational materials for consumers/individuals, guardian, representatives and families. These materials will be posted on the HCBS website and provided in regional information meetings. The initial information will explain the new requirements and how they will be included in the assessment and transition process. The educational information will also explain the impact of the new CFRs and how programs and services are to be integrated in the community and that individuals' have the right to access the broader community in which they live. The information will be routinely updated and posted on the HCBS website. DHS and OHA will recommend that providers hold resident and family meetings.

Provider information meetings and trainings (July 2014 – September 2018) DHS and OHA began meeting with providers and provider associations in July 2014 to inform them of the new regulations, Oregon's conceptual transition plan, and to give providers the opportunities to ask questions and provide initial process input. DHS and OHA will continue to meet with providers and their associations throughout the transition time period. DHS and OHA are developing strategic technical assistance by drafting and issuing fact sheets, frequently asked questions (FAQs), and responding to questions from providers. DHS and OHA will post materials on the HCBS website and provide it in regional trainings. DHS and OHA will host regional trainings throughout the state. At the advice of the Stakeholders, DHS and OHA will invite providers, consumers, family members and delivery system staff members to the same training to ensure that the information is shared consistently to everyone. Trainings will be held during the day and in evenings to facilitate attendance. DHS and OHA will make recordings of the training content available on-line so that interested parties may watch it at their convenience. Initial training activities will focus on the new requirements and how to complete the provider self-assessment.

The training materials will be presented to Stakeholders for review by May 1, 2015. DHS and OHA will post the training materials on the HCBS website. Additional training will be developed and disseminated regarding individual's rights, protections, person-centered planning, community inclusion and how individual "Modifications to the Conditions" during the person-centered planning process will be implemented. DHS and OHA will continue to engage Stakeholders to develop educational materials on how to work with high risk and vulnerable individuals within the new requirements. Additionally, as these are the homes of the individuals we serve, DHS and OHA will provide clarity on the requirement that all provider-owned, operated, or controlled residential settings maintain a "home-like" quality. The information will be routinely updated and posted on the HCBS website.

Delivery System Education (November 2014 – March 2019) DHS and OHA will ensure that service delivery system staff members (case managers, personal agents, service coordinators, licensing staff and protective service staff) receive additional training on Person-Centered Planning philosophy and practice, including the empowerment of the individual to fully understand the full range of options available to them, and their rights in making individual choices. The training will stress that individuals have the right to select where they live and receive services from the full array of available options in Oregon, including services and supports in their own or family homes. The training will include curricula on supporting informed choice, identify areas that providers must address and support implementation of the transition plan. It will also include individuals' rights, protections, person-centered thinking, and community inclusion.

Phase III. Provider Self-Assessment and Individual Experience Assessment (August 2015 – September 2018)

Provider Self-Assessment Tool (August 2015 – September 2015) In Phase I. of the transition plan, DHS and OHA described how they assessed regulatory compliance with the settings requirements for each type of provider-owned, controlled, or operated HCBS setting authorized and funded under 1915(c) waivers, and 1915(i) and 1915(k) State Plan Options.

§1915(i) HCBS State plan Services
State/Territory: Oregon

Phase III of the transition plan details how DHS and OHA will determine compliance with the settings requirements for individual sites within each type of provider-owned, controlled, or operated HCBS setting (e.g. Foster Homes, RTFs etc.) In consultation with Stakeholders, DHS and OHA have developed a Provider Self-Assessment Tool (PSAT) for providers of provider-owned, controlled, or operated residential and non-residential settings. The provider of each site will receive the Provider PSAT with instructions and required timelines for completion. All HCBS providers of provider-owned, controlled, or operated settings will be required to complete the self-assessment for each of those HCBS sites they operate. Providers will be encouraged to include the individuals receiving services, their family members/representatives, advocates and others in their assessment process. Providers will be required to include in their self-assessment a description of their self-assessment process, including participation of any individuals listed previously. DHS and OHA will provide guidance to providers on how to accomplish this activity. Some of the guidance will be fact sheets, instructions, and FAQs. Providers must complete and return the PSAT to DHS and OHA within 60 calendar days of receipt.

Individual Experience Assessment (August 2015 – September 2015) DHS and OHA do not assume any of the individual HCBS sites meet the new regulations. To validate both DHS's and OHA's initial regulatory assessment and the provider self-assessment, DHS and OHA will actively engage with individuals receiving Medicaid-funded HCBS services as specified in this plan, their families and their advocacy organizations to gather their opinion and insight on how providers are meeting the HCBS requirements. In consultation with Stakeholders, DHS and OHA are developing an Individual Experience Assessment (IEA) for individuals receiving Medicaid-funded HCBS services in provider-owned, controlled, or operated residential settings. The IEA will focus primarily on whether the individual feels his or her service experiences align with what is required in the settings requirements. With advice and feedback from Stakeholders, DHS and OHA are determining the best way to maximize individual participation in the IEA process.

All Medicaid-eligible individuals receiving HCBS as identified in this transition plan will receive the opportunity to participate in the IEA process. The results of the IEAs will allow DHS and OHA to gain critical insight about how the individuals receiving services perceive their experiences both with the service delivery system and their service provider. The IEA will indicate if it was completed by the individual, the family, the individual's guardian, or others. Additionally, the IEA will ask if the individual felt that they were able to select their services from all available service options and all available providers. DHS and OHA will provide feedback to the provider, based on their analysis and evaluation of the IEA and require them to address the findings in their final adaptation plan.

Validation of Providers' Self-Assessment (September 2015 – February 2016) The Individual Experience Assessment and Provider Self-Assessment will be conducted simultaneously. DHS and OHA will use a variety of ways to validate the PSAT. The first step is the IEA. Ideally, at least one individual from each provider site will complete and return the IEA. As mentioned above, the IEA will validate or contradict the provider's self-assessment. DHS and OHA will also conduct site visits on a random sample of individual sites, separate from and an in addition to licensing/certification reviews, to determine the validity of the assessment responses. Through education and technical assistance efforts, DHS and OHA will be able to corroborate information provided by providers and service recipients. DHS and OHA will also provide and publicize the opportunity for the public to submit feedback on providers' compliance and/or progress. As a key component, DHS and OHA will ask advocacy organizations, such as the Oregon Long Term Care Ombudsman, to inform DHS and OHA if the Ombudsmen or other advocates have concerns about providers' attestations. DHS and OHA will leverage existing organizational partners such as the Governor's Advocacy Office, adult protective service staff, licensing staff and case managers to assist in validation of assessment results and ongoing provider compliance. Staff from these entities will report concerns or areas of inconsistency. The reports from these staff members will allow the centralized HCBS team to compare complaints, issues and allegations against providers. DHS and OHA anticipate that it will have the completed PSATs and IEAs returned by 09/30/2015. DHS and OHA expect to analyze approximately 4000 completed PSATs. IEAs will be sent to approximately 30,000 individuals receiving services in provider-owned, controlled, or operated residential settings and non-residential settings funded by 1915(c), 1915(i), and/or 1915(k). Dependent upon the rate of return of IEAs, DHS and OHA anticipate that it will take 5 months to compile, analyze and compare the results of the PSATs and IEAs. After results are compiled, analyzed, and compared, as detailed in the attached timeline, DHS and OHA will amend the Global Transition Plan to include assessment results, analysis, and plan for remediation activities.

Oregon anticipates submitting its amended Global Transition Plan on July 1, 2016. The amended plan will also include the aggregated number of sites that fully align with federal requirements, the aggregated number of sites that do not currently comply and require modifications, and the aggregated number of sites that cannot meet the requirements and will require termination of the provider's Medicaid HCBS contract. Additionally, DHS and OHA will identify and provide justification/evidence of any sites not identified in Phase IV below, that are presumptively non-HCBS but for which DHS and OHA will request heightened scrutiny. Prior to submission to CMS of the amended Global Transition Plan, DHS and
OHA will commence a 30 calendar day public notice and comment period with at least one public forum. The public notice will include information about how individuals can request a printed copy of the amended Transition Plan.

Phase IV. Heightened Scrutiny Process (October 2014 – June 2016)
Facilities and Programs Oregon has Initially Identified to Require Heightened Scrutiny Based on an initial offsite review of provider-owned, controlled, or operated residential HCBS settings, Oregon is pro-actively asking CMS to approve the following facility or program types through the heightened scrutiny process. DHS and OHA do not believe that these types of facility or programs in Oregon have the effect of isolating individuals receiving HCBS from the broader community and they serve a critical function in meeting the needs of individuals receiving HCBS. • Facilities in the same building, on the grounds of, or immediately adjacent to, inpatient treatment facilities or public institutions. These facilities or programs will meet the HCBS requirements regardless of the location and will not isolate individuals from the broader community. In some cases, the facilities are co-located with institutions to provide individuals the ability to gain additional skills that allow them to transition to other settings in the community. In other cases, the HCBS setting was not intentionally located adjacent to an inpatient treatment facility or public institution. As an example, an adult foster home, a traditional family home, may be adjacent to the Oregon State Hospital but is operated by an independent provider. These settings are often located where a residential neighborhood begins and individuals have full access to the community. In the few instances where the location of the setting creates concerns of potential isolation from the broader community, DHS and OHA will work with providers to identify additional resources that facilitate increased access to the broader community.

Review for Heightened Scrutiny (October 2014 – June 2016)
Throughout Phase III of the Global Transition Plan, DHS and OHA will assess each site to determine if it does not appear to meet the HCBS settings requirements and requires Heightened Scrutiny. This will include:
• Conducting an initial review of licensing and service delivery system records to determine if the site is in the building of, on the grounds of, or adjacent to an institution. (October 2014)
• Working with stakeholders to create criteria for determining which sites will require Heightened Scrutiny (June 2015).
• Using the provider assessment, IEA responses, and additional criteria to determine and propose if a site meets the definition of an HCBS site. (September 2015 - February 2016)
• Conduct on-site review of sites determined to require heightened scrutiny. (February 2016 – June 2016)
• Posting information on each site that requires Heightened Scrutiny on the HCBS website and asking for public comment. (July 2016)
• Providing opportunity for sites to request an Administrative Review of DHS's and OHA's determination. (August 2016 -September 2016)
• Compiling a report of the settings presumed to require heightened scrutiny and submit evidence and justification to CMS to apply review process (described in Phase III). (September 2016)
• Expected receipt of CMS response. (December 2016)
• Determining remediation strategies and next steps (September 2016 –September 2018)

Phase V. Remediation Activities (May 2015 – September 2018)
After the PSAT and IEA results for all providers are analyzed, DHS and OHA shall supply each provider an initial response detailing findings and the areas that they must change to come into compliance with the HCBS regulations. The initial response will be sent no later than February 2016. The initial response will include a template, developed with Stakeholders, for providers to use to develop a Provider-Specific Adaptation Plan. Upon receipt of the initial response, each provider will have 30 calendar days to provide DHS and OHA additional information rebutting the findings. This submission will trigger a review process through which an administrative review committee (ARC) will make a final determination on the areas that must be remediated. The ARC will make a final determination within 30 calendar days. DHS and OHA will then send the provider a final response detailing the ARC's determination and identify changes that must be addressed in the provider's Adaptation Plan.

Prior to December 2015, DHS and OHA will create an advisory panel, comprised of Stakeholders, to develop evaluation criteria for the Adaptation Plans. The advisory panel will also evaluate the Provider Adaptation Plans, using the developed criteria, and provide recommendations to DHS and OHA to ensure the plans meet HCBS regulations. This advisory panel will provide critical insight as DHS and OHA determine if providers have submitted satisfactory Adaptation Plans. Plans that do not meet the requirements will be returned to the providers/programs for necessary changes.
Providers/programs who do not agree with DHS's and OHA's evaluation of the Adaptation Plan may request an administrative review of the determination within 30 calendar days of receiving DHS's and OHA's decision. DHS and OHA will make a final decision within 30 calendar days of receiving the request for an administrative review. Approved Adaptation Plans will be posted on the HCBS website. DHS and OHA will redact any individually identifiable or confidential information before posting. DHS and OHA will ensure that sites are making progress towards compliance through licensing and service delivery system staff visits. A reporting mechanism will be created by DHS and OHA to allow these staff to report individual providers' progress.
For sites that are not licensed, contract compliance staff will review providers annually to ensure that these provider types are meeting the requirements. DHS and OHA will also develop a scorecard of provider's progress towards implementing the new requirements and post it on the HCBS website. This scorecard will allow the public to view the provider's assessment of their status. DHS and OHA will require that providers submit their FINAL Adaptation Plan no later than December 31, 2016. For providers needing assistance to come into compliance DHS and OHA shall:
• Facilitate regional focus groups of providers who can talk through provider specific issues and problem-solve how to achieve compliance together. Participation will be voluntary and can include individuals and family members who may aid in the problem solving process.
• Provide direct technical assistance at the request of the provider.
• Provide information on the HCBS website to guide providers in making the necessary changes.

Phase VI. Ongoing Compliance and Oversight (May 2015 – Ongoing)
Oregon will assess providers' progress towards compliance through reports, interviews and on-site inspections that include information from providers and individuals receiving services. Licensing and service delivery system staff will be critical to ensuring compliance and assuring providers' progress on their adaptation plans. DHS and OHA will ensure that these staff members are appropriately trained on the new regulations and expectations. Additionally, ongoing surveys of individuals will ensure that providers reach compliance. With the Stakeholders, DHS and OHA will develop processes, data elements and other aspects to measure the impact of the changes on individuals receiving services.

DHS and OHA will report out the compiled data on a regular basis and post information on the HCBS website. Once overall compliance is achieved, strategies to ensure ongoing compliance will include:
• Conducting the Individual Experience Assessment biennially;
• Building questions from the individual's experience assessment into annual service planning processes; • Ongoing licensing inspections by licensing staff; and
• Oregon's quality management system will include ongoing HCBS setting compliance monitoring to ensure that settings continue to comply with the HCBS Setting Rule. Throughout the Transition Plan, DHS and OHA will work closely with the Stakeholders to ensure that DHS and OHA have a robust view on the progress towards successful implementation of the Transition Plan and the changes necessary to reach lasting compliance. DHS and OHA will engage Stakeholders and other avenues to evaluate progress, identify areas of concern, and propose solutions. This transition process will be transparent to Stakeholders and the broader public. Providers must be in full compliance with the regulations by September 30, 2018. This timeline assures that DHS and OHA have adequate time to assist individuals, using a person-centered planning process, to choose alternative services and settings options if their individual provider is unable to meet full compliance, If, by September 30, 2018, the provider is not in full compliance, DHS and OHA will begin working with individuals and their family members or representatives to transition to a site that is in compliance. This will allow more than 5 full months to transition individuals by CMS's final compliance deadline. Individuals must be moved to compliant sites by February 28, 2019. Medicaid contracts for providers who are not willing or able to come into compliance with the regulations will be terminated no later than February 28, 2019. DHS and OHA will notify service recipients in writing by 09/30/2018 if their current provider is not in compliance with the HCBS regulations. The notification will explain the individual's rights and options available to them. It will also define the process and timeline to help the individual make an informed choice of another site that is in compliance. Individuals will be able to select from all available settings. Service delivery system staff will assist individuals and their representatives in the person-centered service planning process and will ensure that all critical services and supports are in place prior to the individual transitioning to another site. Providers who are unable to come into compliance will no longer be able to contract with DHS and OHA effective March 1, 2019. Providers who are not able to achieve full compliance by September 30, 2018 will be required to assist the DHS and OHA in transitioning individuals by February 28, 2019 to other sites that are in compliance.

Key Action Items	Approx. Start Date (first day of month)		Approx. End Date (last day of month)
Pre Plan Activities			
Meetings with provider associations	Jul- 14		Sep- 14
Convene a HCBS Transition Stakeholder Group	Aug- 14		Sep- 19
HCBS Transition Stakeholder Kick-off meeting	Aug- 14		Aug- 14
Phase I- Initial Regulatory Assessment			
Complete an initial assessment of Oregon's residential and nonresidential settings' regulatory compliance with the CFRs	Jun- 14		Jan - 15
Share scorecard with stakeholders	Aug- 14	and	Mar- 15
Post scorecard on Oregon HCBS Website	Aug- 14, Sep- 14,	and	Mar- 15
Oregon Transition Plan Development and Submission			
Write draft Transition Plan	Aug- 14		Aug- 14
Stakeholder review of draft transition plan	Aug- 14		Aug- 14
Public Comment Period: September 5, 2014	Sep- 14		Oct- 14
End of Public Comment Period: (October 5, 2014)	Oct- 14		Oct- 14
Transition Plan Submitted to CMS	Oct- 14		Oct- 14
Expected response from CMS	Jan- 15		Jan- 15
Response to CMS's request for additional information	Jan- 15		Apr- 15
Phase II- Statewide Training and Education Efforts			
Meet with providers and associations	Jul- 14		Ongoing
Develop educational materials for individuals, providers, and Case Managers including FAQs and Fact Sheets	Oct- 14		Ongoing
Share materials with stakeholders	Apr- 15		Ongoing
Post materials on website	May- 15		Ongoing
Host regional training and information meetings for individuals, providers, and case managers	Jun- 15		Jul- 15
Phase III- Provider Self-Assessment and Individual Experience Assessment			
Provider Self-Assessment			
Develop Provider Self-Assessment Tool (residential and nonresidential providers)	Oct- 14		Apr- 15
Share with Transition Stakeholder Group	May- 15		May- 15
Develop online survey tool	Jun- 15		Jul- 15

Key Action Items	Approx. Start Date (first day of month)	Approx. End Date (last day of month)
Pre Plan Activities		
Develop online survey tool	Jun- 15	Jul- 15
Send provider self-assessment to residential and non-residential providers	Aug- 15	Aug- 15
Provider Self-Assessments completed and returned to State	Aug- 15	Sep- 15
Individual Experience Assessment		
Develop a survey for individuals receiving services	Oct- 14	Apr- 15
Share survey with Transition Stakeholder Group	May- 15	May- 15
Develop online survey tool	Jun- 15	Jul- 15
Send Individual Experience Assessments to individuals receiving HCBS	Aug- 15	Aug- 15
State and partners to conduct individual assessments as necessary (in-person, phone)	Aug- 15	Sep- 15
Individual Experience Assessments completed and returned to State	Aug- 15	Sep- 15
Provide technical assistance to individuals	Aug- 15	Sep- 15
Provider Self-Assessment and Individual Experience Assessment Results and Responses		
Develop and disseminate Adaptation Plan template for providers to develop their individual Adaptation Plan	Jun- 15	Jul- 15
State evaluates Individual Experience Assessments and Provider Self-Assessments (comparison of results from both)	Sep- 15	Feb- 16
State to provide initial notice of findings, including Adaptation Plan template, to residential and non-residential providers and recommendations for Adaptation plans	Sep- 15	Feb- 16
Providers may request a review of State's initial findings	Mar- 16	Mar- 16
State responds to provider's request for review of initial findings	Apr- 16	Apr- 16

Key Action Items	Approx. Start Date (first day of month)	Approx. End Date (last day of month)
Pre Plan Activities		
Submission of Amended Global Transition Plan		
State evaluates Individual Experience Assessments and Provider Self-Assessments (comparison of results from both)	Sep- 15	Feb- 16
State identifies necessary Transition Plan changes	Sep- 15	Feb- 16
State identifies settings that require heightened scrutiny	Feb- 16	Jun- 16
State amends Global Transition Plan	Mar- 16	Mar- 16
Stakeholder review of draft transition plan	Apr- 16	Apr- 16
30-day Public Comment Period	May- 16	Jun- 16
Amended Global Transition Plan Submitted to CMS	Jul- 16	Jul- 16
Expected response from CMS	Oct- 16	Oct- 16
Phase IV. Heightened Scrutiny Process		
State evaluates Individual Experience Assessments and Provider Self-Assessments (comparison of results from both) and identifies settings that require heightened scrutiny	Sep- 15	Feb- 16
State conducts on-site reviews of settings identified to require heightened scrutiny per CMS's regulations	Feb- 16	Jun- 16
State submits evidence and justification to CMS for each setting that is presumed to be non-HCB but the State has determined to meet HCB requirements to apply heightened scrutiny review process	Sep- 16	Sep- 16
Phase V- Remediation Activities		
Adaptation Plans		
Update website to guide providers in making the necessary changes.	May- 15	Ongoing
Develop with Stakeholders an advisory panel and Adaptation Plan review criteria	May- 15	Dec- 15
Providers submit Adaptation Plans addressing State's findings	May- 16	Jun- 16

Key Action Items	Approx. Start Date (first day of month)	Approx. End Date (last day of month)
Pre Plan Activities		
State and advisory panel review providers' Adaptation Plan and provides approval or denial of Plan	Jul- 16	Aug- 16
Providers may appeal the State's denial	Sep- 16	Sep- 16
State's will review appeal evidence and issue a final decision	Oct- 16	Oct- 16
Providers submit FINAL Adaptation Plan addressing State's findings	Nov- 16	Dec- 16
Develop a scorecard of provider's compliance	Jan- 17	Feb- 17
Post scorecard on website	Mar- 17	Mar- 17
Gather public input on provider's assessment	Apr- 17	Sep- 18
OAR, 1915(c) waivers, and 1915(i) and 1915(k) State Plan Amendment (SPA) Changes Assess OARs, waivers, and SPAs for needed changes	Oct- 14	Apr- 15
Work with stakeholders to identify and address necessary OAR, waivers, and SPA changes	Apr- 15	May- 15
Conduct formal rule making process	Jun- 15	Jan- 16
Public Notice and Submission of any necessary waiver amendments and SPAs.	Mar- 16	Dec- 16
Modifications to Conditions (Service Plans)		
Develop policies and procedures on individual service plan modifications	Jan-15	Dec-15
Create expectations and a method for collecting data on an ongoing basis to measure the effectiveness of the modification	Jan- 15	Jul- 15
Develop timeframes for review of the data and effectiveness of the modification to ensure it continues to be appropriate.	Jan- 15	Dec- 15

Key Action Items	Approx. Start Date (first day of month)	Approx. End Date (last day of month)
Pre Plan Activities		
Achieving Initial Compliance		
Develop procedures for interviewing providers, individuals, family members and program inspections	Jan- 15	Jul- 15
Develop policies and procedures for Quality Assurance and Licensing staff to check progress on their adaptation plans.	May- 15	Jan- 16
Phase VI- Ongoing Compliance and Oversight		
Develop ongoing monitoring and quality assurance processes	May- 15	May- 18
Assist individuals in finding and transitioning to alternative settings	Sep- 18	Feb- 19
Terminate Medicaid contracts with non-compliant providers	Mar- 19	Mar- 19
2nd Individual Experience Assessment	Jul- 17	Dec- 17
3rd Individual Experience Assessment	Jul- 19	Dec- 19

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

Staff of the IQA who are Qualified Mental Health Professional (QMHP) as identified below in section 5. QMHP's conduct face to face evaluation of individual support needs and capabilities for individuals residing in the community. The IQA reviews the assessment when conducting medical appropriateness reviews. For individuals in the community, OHA licensed level of care and eligible individuals transitioning from a hospital level of care, staff of the IQA who are a qualified mental health professional are responsible for conducting the face to face assessment and developing a person centered plan.

5. **Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Staff of the IQA who are Qualified Mental Health Professional (QMHP)
Qualifications for a QMHP are:
Graduate degree in psychology; or
Bachelor's degree in nursing and be licensed by the State of Oregon; or
Graduate degree in social work; or
Graduate degree in a behavioral science field; or
Graduate degree in recreational, art, or music therapy; or
Bachelor's degree in occupational therapy and be licensed by the State of Oregon;
AND

Education and experience which demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multi-axial DSM diagnosis; write and supervise a treatment plan, conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of practice.

6. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The IQA works with the person and/or their representative to establish a time to engage with the person in their current location or a location of their choosing. When establishing an initial meeting, the IQA case worker will inform the person of their choice to include others that may have information about their needs or people that are important to them or who are a support to them. During the initial interaction or engagement with the person, the IQA case manager provides information to the person (and/or those individuals chosen by the person) regarding eligibility and referral processes, available benefits, resources, services and supports covered under the 1915(i) HCBS services. Through the person centered assessment and planning process, the IQA assists the person to identify the services, supports and benefits available to them which can assist them to achieve the goals or outcomes the person has identified and important to them. During this process, the IQA case manager provide education, instruction and information about the person-centered assessment and planning process, and how it is applied, the range and scope of individual choices and options, the process for changing the person-centered service plan, grievance and appeals process, individual rights, risks and responsibilities of self-direction, free choice of providers and service delivery models, reassessment and review schedules, defining goals, needs and preferences, identifying and accessing services, supports and resources, development of risk management agreements, and recognizing and reporting critical events, including abuse investigations. These supports are provided verbally and in writing in a manner and language easily understood by the person and others the person has chosen to participate in the person centered assessment and planning process. The IQA has developed print and online information about home and community based services and supports, including information about available providers, services and the processes to referral and access to HCBS covered services and providers. www.ohpcc.org

7. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. *(Describe the process by which the person-centered service is made subject to the approval of the Medicaid agency):*

Using the needs based criteria and the requirement in HSD administrative rule for medical appropriateness, prior authorization and prior authorization of residential services, the IQA will conduct medical appropriateness reviews of all services recommended or identified through the needs based evaluation and person centered planning process, which will include; individualized treatment objectives, the specific services and supports that will be used to meet the treatment objectives, a projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session or encounter, the type of personnel that will be furnishing, and a projected schedule for re-evaluating the service plan. The IQA will provide recommendation to HSD for approval, admission, continued stay, increase, reduction or denial of HCBS services. HSD will prior authorize, reduce or deny services. OHA reviews the IQA recommendations using the standards for Person-centered Planning contained in the IQA contract.

(1) Contractor shall develop a person-centered plan of care that reflects the services and supports, and the delivery of such services and supports, which are important to the Recipient. Recipient directs the process to the maximum extent possible and is enabled to make informed choices and decisions. Persons chosen by the Recipient are included in the planning.

(2) Contractor shall provide necessary information in plain language in a manner accessible to individuals with disabilities and persons whose English proficiency is limited. Cultural factors must be considered.

(3) Contractor shall prepare the written plan of care commensurate with the Recipient's level of need and the scope of the services and supports available that reflects the Recipient's strengths and preferences and includes individually identified goals and desired outcomes.

(4) Contractor shall describe any clinical and support needs identified through a functional needs assessment and indicate the paid and unpaid services and supports and the providers responsible for implementation.

(5) Contractor shall include risk factors and measures to minimize the risk factors, such as individualized backup plans and strategies.

(6) Contractor shall document and justify any modification that supports a specific and individualized assessed need.

OHA will review a representative sample of person centered plans recommended by the IQA using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.

OHA staff provide technical assistance to the person, IQA and providers when applicable regarding recommendations and when needed, implements corrective action plans with the contract to ensure compliance with contractual requirements and HCBS and/or Oregon administrative rules.

8. Maintenance of Person-Centered Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☑	Medicaid agency	☐	Operating agency	☐	Case manager
☑	Other (*specify):*	IQA			

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	**Home Based Habilitation**
Service Definition (Scope)*:*	
Habilitation services that support and individual to maintain, learn, or improve skills and functioning in their activities of daily living and instrumental activities of daily living. Habilitation is aimed at raising the level of physical, mental, and social functioning of an individual. Habilitation is contrasted to rehabilitation which involves the restoration of function that a person has lost. Home Based Habilitation is based on an individual's needs as identified in a needs assessment. Habilitation includes:: o Assistance or support with IADL and ADLs o Resources for individualized person centered services and supports o Resources to support community inclusion and navigation o Services to maintain and develop skills that aid in an individual's ability to live in the most integrated community setting. Services and supports may be delivered in licensed and non-licensed home and community based settings that are not considered secure.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications (For each type of provider. Copy rows as needed):

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Foster Home	OHA		OAR 309-040-0000
Residential Treatment Home or Facility	OHA		OAR 309-035-0300
Qualified Mental Health Professional	Board of Nursing; Occupational Therapy Licensing Board	QMHP are licensed or supervised by a board licensed provider under a board approved plan of practice and supervision or be employed by or contracted with a provider organization certified by OHA as described in OAR 309-012-0130 through 309-012-0220	Graduate degree in psychology; or Bachelor's degree in nursing and be licensed by the State of Oregon; or Graduate degree in social work; or Graduate degree in a behavioral science field; or Graduate degree in recreational, art, or music therapy; or Bachelor's degree in occupational therapy and be licensed by the State of Oregon; AND Education and experience which demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts;

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Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Qualified Mental Health Professional (Cont)			assess family, social and work relationships; conduct a mental status examination; document a multi-axial DSM diagnosis; write and supervise a treatment plan, conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of practice
Qualified Mental Health Associate		QMHA providers shall be employed by or contracted with a provider organization certified by OHA as described in OAR 309-012-0130 through 309-012-0220	"Qualified Mental Health Associate" or "QMHA" means a person delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) and meeting the following minimum qualifications as documented by the LMHA or designee: (a) A bachelor's degree in a behavioral sciences field; or (b) A combination of at least three year's relevant work, education, training or experience; and (c) Has the competencies necessary to: (A) Communicate effectively; (B) Understand mental health assessment, treatment and service terminology and to apply the concepts; and (C) Provide psychosocial skills development and to implement interventions prescribed on a Treatment Plan within the scope of his or her practice.
Certified peer Services Support Specialist		Certified by the Oregon Office of Addiction Counselor Certification Board of Oregon (ACCB) and Office of Equity and Inclusion (OEI)	"Peer Support Specialist" means a person providing peer delivered services to an individual or family member with similar life experience. A peer support specialist must be: (a) A self-identified person currently or formerly receiving mental health services; or (b) A self-identified person in recovery from an addiction disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; (c) A self-identified person in recovery from problem gambling; or (d) A family member of an individual who is a current or former recipient of addictions or mental health services.

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Certified peer Services Support Specialist (Cont)		and be employed by or contracted with a provider organization certified by OHA as described in OAR 309-012-0130 through 309-012-0220	
Recovery Assistant		employed by or contracted with a provider organization certified by OHA as described in OAR 309-012-0130 through 309-012-0220	(8)"Recovery Assistant" means a provider who provides a flexible range of services. Recovery assistants provide face-to-face services in accordance with a service plan that enables a participant to maintain a home or apartment, encourages the use of existing natural supports, and fosters involvement in treatment, social, and community activities. A recovery assistant shall: (a) Be at least 18 years old; (b) Meet the background check requirements described in OAR 410-180-0326; (c) Conform to the standards of conduct as described in OAR 410-180-0340.
Mental Health Intern		employed by or contracted with a provider organization certified by OHA as described in OAR 309-012-0130 through 309-012-0220	1) A qualified provider is a person who, in the judgment of the Department or its designee, can demonstrate by background, skills and abilities the capability to safely and adequately provide the services authorized. (2) A qualified provider must maintain a drug-free work place and must be approved through the criminal history check process described in OAR chapter 407, division 007. (3) A qualified provider paid by the Department must not be the parent, or step-parent of an eligible minor child, the eligible individual's spouse or another legally responsible relative.

Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Mental Health Intern (Cont)			(4) A qualified provider must be authorized to work in the Unit States, in accordance with U.S. Department of Homeland Security, Bureau of Citizenship and Immigration rules. 8) Criminal History Re-checks: (a) Criminal history re-checks may be conducted at the discretion of the Department or designee, in accordance with OAR chapter 407, division 007. (b) Providers must comply with criminal history re-checks by completing a new criminal history authorization form when requested to do so by the Department. The provider's failure to complete a new criminal history check authorization will result in the inactivation of the provider enrollment Once inactivated, a provider must reapply and meet all of the standards described in this rule to have their provider enrollment reactivated. (9) Provider must not be included on any US Office of Inspector General Exclusion lists.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Adult Foster Home	Health Services Division	**Every year**
Residential Treatment Facility/Home	Health Services Division	**Every two years**
QMHP	Local Mental Health Authority	**Every three years**
QMHA	Local Mental Health Authority	**Every three years**

Certified Peer Services Support Specialist	Addiction Counselor Certification Board of Oregon (ACCB) and Office of Equity and Inclusion (OEI)	**Every two years**
Recovery Assistant	Local Mental Health Authority and Mental Health Organization	**Every three years**
Mental Health Intern	Local Mental Health Authority	**Every Two Years**

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	**HCBS Behavioral Habilitation**
Service Definition (Scope)*:*	
Services include o Behavior Support o Training and Education- Psychosocial skills o Activity Therapy -Group and generalized services administered by a qualified provider such as expressive, art, dance, exercise or play therapies provided for reasons other than recreation and that result in the improvement or reduction of the symptoms associated with a diagnosed behavioral health condition. Services may be delivered in the community, adult foster home, residential treatment home or residential treatment facilities that are not considered secured. Persons receiving these services would not qualify for similar services funded under section 110 of Rehabilitation Act 1973 or Individual with Disabilities Improvement Act of 2004.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Service Title:	**HCBS Behavioral Habilitation** –Continued
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):	
☐	Categorically needy *(specify limits):*

Service Title:	**HCBS Behavioral Habilitation** –Continued
☐	Medically needy *(specify limits):*

Provider Qualifications (For each type of provider. Copy rows as needed):

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Adult Foster Home	OHA		OAR 309-040-0000
Residential Treatment Home or Facility	OHA		OAR 309-035-0300
Qualified Mental Health Professional	Board of Nursing; Occupational Therapy Licensing Board	QMHP are licensed or supervised by a board licensed provider under a board approved plan of practice and supervision or be employed by or contracted with a provider organization certified by OHA as described in OAR 309-012-0130 through 309-012-0220	Graduate degree in psychology; or Bachelor's degree in nursing and be licensed by the State of Oregon; or Graduate degree in social work; or Graduate degree in a behavioral science field; or Graduate degree in recreational, art, or music therapy; or Bachelor's degree in occupational therapy and be licensed by the State of Oregon; AND Education and experience which demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; document a multi-axial DSM diagnosis; write and supervise a treatment plan, conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of practice

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Qualified Mental Health Associate		QMHA providers shall be employed by or contracted with a provider organization certified by OHA as described in OAR 309-012-0130 through 309-012-0220	"Qualified Mental Health Associate" or "QMHA" means a person delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) and meeting the following minimum qualifications as documented by the LMHA or designee: (a) A bachelor's degree in a behavioral sciences field; or (b) A combination of at least three year's relevant work, education, training or experience; and (c) Has the competencies necessary to: (A) Communicate effectively; (B) Understand mental health assessment, treatment and service terminology and to apply the concepts; and (C) Provide psychosocial skills development and to implement interventions prescribed on a Treatment Plan within the scope of his or her practice.
Certified peer Services Support Specialist		Certified by the Oregon Office of Addiction Counselor Certification Board of Oregon (ACCB) and Office of Equity and Inclusion (OEI)	“Peer Support Specialist” means a person providing peer delivered services to an individual or family member with similar life experience. A peer support specialist must be: (a) A self-identified person currently or formerly receiving mental health services; or (b) A self-identified person in recovery from an addiction disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs;

Certified peer Services Support Specialist (Cont)		and be employed by or contracted with a provider organization certified by OHA as described in OAR 309-012-0130 through 309-012-0220	(c) A self-identified person in recovery from problem gambling; or (d) A family member of an individual who is a current or former recipient of addictions or mental health services.
Recovery Assistant		employed by or contracted with a provider organization certified by OHA as described in OAR 309-012-0130 through 309-012-0220	(8)"Recovery Assistant" means a provider who provides a flexible range of services. Recovery assistants provide face-to-face services in accordance with a service plan that enables a participant to maintain a home or apartment, encourages the use of existing natural supports, and fosters involvement in treatment, social, and community activities. A recovery assistant shall: (a) Be at least 18 years old; (b) Meet the background check requirements described in OAR 410-180-0326; (c) Conform to the standards of conduct as described in OAR 410-180-0340.

Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Mental Health Intern		employed by or contracted with a provider organization certified by OHA as described in OAR 309-012-0130 through 309-012-0220	1) A qualified provider is a person who, in the judgment of the Department or its designee, can demonstrate by background, skills and abilities the capability to safely and adequately provide the services authorized. (2) A qualified provider must maintain a drug-free work place and must be approved through the criminal history check process described in OAR chapter 407, division 007. (3) A qualified provider paid by the Department must not be the parent, or step-parent of an eligible minor child, the eligible individual's spouse or another legally responsible relative. (4) A qualified provider must be authorized to work in the Unit States, in accordance with U.S. Department of Homeland Security, Bureau of Citizenship and Immigration rules. 8) Criminal History Re-checks: (a) Criminal history re-checks may be conducted at the discretion of the Department or designee, in accordance with OAR chapter 407, division 007. (b) Providers must comply with criminal history re-checks by completing a new criminal history authorization form when requested to do so by the Department. The provider's failure to complete a new criminal history check authorization will result in the inactivation of the provider enrollment. Once inactivated, a provider must reapply and meet all of the standards described in this rule to have their provider enrollment reactivated. (9) Provider must not be included on any US Office of Inspector General Exclusion lists.

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Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Adult Foster Home	Health Services Division	**Every year**
Residential Treatment Facility/Home	Health Services Division	**Every two years**
QMHP	Health Services Division	**Every three years**
QMHA	Local Mental Health Authority	**Every three years**
Certified Peer Services Support Specialist	Addiction Counselor Certification Board of Oregon (ACCB) and Office of Equity and Inclusion (OEI)	**Every two years**
Recovery Assistant	Local Mental Health Authority and Mental Health Organization	**Every three years**
Mental Health Intern	Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT) and Oregon Board of Licensed Social Worker (OLCSW)	**Every Two Years**

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title:	**HCBS Psychosocial Rehabilitation for persons w. CMI**

Service Definition (Scope)*:*

Services include:

- Comprehensive Medication Services (LMP)
- Individual Therapy
- Group Therapy
- Family Therapy
- Psychiatric Skills Training
- Behavioral health counseling therapy
- Psychiatric Activity Therapy/Community Psychiatric Supportive Treatment- Individualized and specific services administered by a qualified provider that promote community stabilization, integration, socialization, inclusion and skill acquisition to improve a person's ability to engage in community, home, school, work and family and overall integration and contribution to their community.
- Assertive Community Treatment

Service Title:	**HCBS Psychosocial Rehabilitation for persons w. CMI** (Continued)

Service Definition (Scope)*:*

May be delivered in the community, adult foster home, residential treatment home or residential treatment facilities that are not considered secured.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications (For each type of provider. Copy rows as needed):

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Qualified Mental Health Professional	Board of Nursing; Occupational Therapy Licensing Board	QMHP are licensed or supervised by a board licensed provider under a board approved plan of practice and supervision or be employed by or contracted with a provider organization certified by OHA as described in OAR 309-012-0130 through 309-012-0220	Graduate degree in psychology; or Bachelor's degree in nursing and be licensed by the State of Oregon; or Graduate degree in social work; or Graduate degree in a behavioral science field; or Graduate degree in recreational, art, or music therapy; or Bachelor's degree in occupational therapy and be licensed by the State of Oregon; AND Education and experience which demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts;

Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Qualified Mental Health Professional (Cont)			assess family, social and work relationships; conduct a mental status examination; document a multi-axial DSM diagnosis; write and supervise a treatment plan, conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of practice
Qualified Mental Health Associate		QMHA providers shall be employed by or contracted with a provider organization certified by OHA as described in OAR 309-012-0130 through 309-012-0220	"Qualified Mental Health Associate" or "QMHA" means a person delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) and meeting the following minimum qualifications as documented by the LMHA or designee: (a) A bachelor's degree in a behavioral sciences field; or (b) A combination of at least three year's relevant work, education, training or experience; and (c) Has the competencies necessary to: (A) Communicate effectively; (B) Understand mental health assessment, treatment and service terminology and to apply the concepts; and (C) Provide psychosocial skills development and to implement interventions prescribed on a Treatment Plan within the scope of his or her practice.

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Certified peer Services Support Specialist		Certified by the Oregon Office of Addiction Counselor Certification Board of Oregon (ACCB) and Office of Equity and Inclusion (OEI) and be employed by or contracted with a provider organization certified by OHA as described in OAR 309-012-0130 through 309-012-0220	"Peer Support Specialist" means a person providing peer delivered services to an individual or family member with similar life experience. A peer support specialist must be: (a) A self-identified person currently or formerly receiving mental health services; or (b) A self-identified person in recovery from an addiction disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; (c) A self-identified person in recovery from problem gambling; or (d) A family member of an individual who is a current or former recipient of addictions or mental health services.
Mental Health Intern			(1)A qualified provider is a person who, in the judgment of the Department or its designee, can demonstrate by background, skills and abilities the capability to safely and adequately provide the services authorized. (2) A qualified provider must maintain a drug-free work place and must be approved through the criminal history check process described in OAR chapter 407, division 007.

Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Mental Health Intern (Cont)			(3) A qualified provider paid by the Department must not be the parent, or step-parent of an eligible minor child, the eligible individual's spouse or another legally responsible relative. (4) A qualified provider must be authorized to work in the Unit States, in accordance with U.S. Department of Homeland Security, Bureau of Citizenship and Immigration rules. 8) Criminal History Re-checks: (a) Criminal history re-checks may be conducted at the discretion of the Department or designee, in accordance with OAR chapter 407, division 007. (b) Providers must comply with criminal history re-checks by completing a new criminal history authorization form when requested to do so by the Department. The provider's failure to complete a new criminal history check authorization will result in the inactivation of the provider enrollment. Once inactivated, a provider must reapply and meet all of the standards described in this rule to have their provider enrollment reactivated. (9) Provider must not be included on any US Office of Inspector General Exclusion lists.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
QMHP	Health Services Division	**Every three years**
QMHA	Local Mental Health Authority	**Every three years**
Certified Peer Services Support Specialist	Addiction Counselor Certification Board of Oregon (ACCB) and Office of Equity and Inclusion (OEI)	**Every two years**
Mental Health Intern	Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT) and Oregon Board of Licensed Social Worker (OLCSW)	**Every Two Years**

2. ☑ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

All 1915(i) HCBS services require prior authorization prior to service delivery or payment.
a) Providers who can be paid for 1915(i) services must meet all necessary Provider Qualifications for a recovery assistant as defined in OAR 410-172-0600(8); Are enrolled as a Medicaid provider and have a history of providing HCBS home based Habilitation service to other HCBS recipients; and Other or alternative home based Habilitation resources are not available to meet the participant's needs as defined in their plan of care.
(b) the 1915(i) services provided are Home Based Habilitation;

Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians (Cont)

(c) OHA ensures that the provision of services by such persons is in the best interest of the individual are by case management monitoring will be increased and ongoing attempts to provide the service in an alternative setting will be part of the participants' service plan. As always the planning process is a collaborative one including the direct opinion of the service recipient so any concerns about the service provider, relative or not, is documented and may be directly discussed with the MHO or LMHA at the individual's request.

(d) When OHA provides for extraordinary care payments to legally responsible individuals for the provision of habilitation services, case management monitoring by the independent entity will be increased and ongoing attempts to provide the service in an alternative setting will be part of the participants' service plan.

(e) OHA has administrative rules in place regarding prior authorization, billing and payment and post payment review to ensure services are rendered prior to payment. Additionally, OHA's Medicaid management information system contains multiple automated functions to ensure payments for Home Based Habilitation will be made to a relative of the participant only if they meet the requirements in (a) above.

(f) OHA will ensure reimbursement of services provided by legally responsible adults will only be made for services rendered by: requiring pre-authorization and post payment review activities to be conducted by the independent entity; and OHA will maintain prior authorization and post payment review policies and procedures based on applicable administrative rule for reimbursement of HCBS services and the contract between OHA and the independent entity.

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Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (*Select one):*

●	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction(Provide an overview of the opportunities for participant-*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

***5.* Financial Management.** (*Select one):*

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. ***(****Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

○	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

○	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	**Service plans a) address assessed needs of 1915(i) participants;**
Discovery	
Discovery Evidence *(Performance Measure)*	(1) Number and percent of participants whose services are delivered in the type, scope, amount, duration and frequency in accordance with the service plan. N: Number of participants whose services were delivered in the type, scope, amount, duration and frequency in accordance with the service plan. D: Total number of participants service plans reviewed (2) Number and percent of participants service plans in which risks and safety factors are addressed N: Number of service plans in which risks and safety factors are addressed D: Total number of service plans reviewed (3) Number and percent of participants whose service plans include services and supports that address assessed needs. N: Number of participants whose service plans include services and supports that address assessed needs. D: Total number of participants reviewed. (4) Number and percent of participants whose service plans address personal goals and preferences. N: Number of service plans in which personal goals and preferences are addressed. D: Total number of service plans reviewed.
Discovery Activity *(Source of Data & sample size)*	Data Source: Record Review – Off-site Sampling Approach: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HSD MPU
Frequency	QTRLY

§1915(i) HCBS State plan Services
State/Territory: Oregon

Service plans a) (Cont)

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) Contractor will conduct defined periodic review of approved services to determine the authorized service is provided in accordance with applicable Oregon Administrative Rules and the service meets the criteria for quality and medical appropriateness and person centeredness. (2) Contractor shall determine type and frequency of review based on the type of service and authorization parameters. Reviews shall be conducted through onsite visit, face to face interview of Recipient or provider, document review, clinical documentation review or data analysis. (1) For each treatment episode monitoring service invoiced to OHA, Contractor shall provide OHA a treatment episode monitoring detail report describing the reason for the review, the type of review, and the outcome of the review. OHA will not issue payment for these services until this condition is met. .
Frequency *(of Analysis and Aggregation)*	(1) Contractor will conduct self-defined periodic review of approved services to determine the authorized service is provided in accordance with applicable Oregon Administrative Rules and the service meets the criteria for quality and medical appropriateness and person centeredness. (2) Contractor shall determine type and frequency of review based on the type of service and authorization parameters. Reviews shall be conducted through onsite visit, face to face interview of Recipient or provider, document review, clinical documentation review or data analysis. (3) For each treatment episode monitoring service invoiced to OHA, Contractor shall provide OHA a treatment episode monitoring detail report describing the reason for the review, the type of review, and the outcome of the review. OHA will not issue payment for these services until this condition is met.

Requirement	Service plans b) are updated annually;
Discovery	
Discovery Evidence *(Performance Measure)*	Percent of service plans that were reviewed, and (1) revised as warranted based on the participant's changing needs; and/or (2) revised within 12 months of their last evaluation when services continued for more than 12 months. N: Number of service plans that were updated/revised as needs changed or every 12 months D: Total number of service plans reviewed
Discovery Activity *(Source of Data & sample size)*	Data Source: Record Review – Off-site Sampling Approach: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology. .
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HSD MPU
Frequency	QTRLY
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	1) IQA will conduct defined periodic review of approved services to determine the authorized service is provided in accordance with applicable Oregon Administrative Rules and the service meets the criteria for quality and medical appropriateness and person centeredness. (2) IQA shall determine type and frequency of review based on the type of service and authorization parameters. Reviews shall be conducted through onsite visit, face to face interview of Recipient or provider, document review, clinical documentation review or data analysis. (1) For each treatment episode monitoring service invoiced to OHA, Contractor shall provide OHA a treatment episode monitoring detail report describing the reason for the review, the type of review, and the outcome of the review. OHA will not issue payment for these services until this condition is met.

Service plans b) (Cont)

Remediation	
Frequency *(of Analysis and Aggregation)*	(1) Contractor will conduct self-defined periodic review of approved services to determine the authorized service is provided in accordance with applicable Oregon Administrative Rules and the service meets the criteria for quality and medical appropriateness and person centeredness. (2) Contractor shall determine type and frequency of review based on the type of service and authorization parameters. Reviews shall be conducted through onsite visit, face to face interview of Recipient or provider, document review, clinical documentation review or data analysis. (3) For each treatment episode monitoring service invoiced to OHA, Contractor shall provide OHA a treatment episode monitoring detail report describing the reason for the review, the type of review, and the outcome of the review. OHA will not issue payment for these services until this condition is met.

Requirement	Service plans c) document choice of services and providers
Discovery	
Discovery Evidence *(Performance Measure)*	(1) Number and percent of participants who are offered choice among services and providers N: Number of participants who are offered choice among services and providers D: Total number of files reviewed
Discovery Activity *(Source of Data & sample size)*	Data Source: Record Review – Off-site Sampling Approach: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HSD MPU
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Provider will be contacted for 100% of participant charts indicating a lack of afforded choice. Provide TA to providers as needed
Frequency (of Analysis and Aggregation)	Within 90 days of the discovery of evidence

2. Providers meet required qualifications.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	**Providers meet required qualifications.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of providers who meet required provider qualifications N: Number of providers who meet required provider qualifications D: Total number of providers reviewed
Discovery Activity *(Source of Data & sample size)*	Data Source: Record Review – Off-site Sampling Approach: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HSD Licensing and Certification Unit
Frequency	RTFs and RTHs reviewed every 2 years, AFHs reviewed every year
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	If provider is not in compliance with minimum requirements, provider must submit CAP. Non-compliance with approved CAP/ failure to develop an approved CAP will lead HSD to work with MHOs to seek alternate services and informing the License/ Cert Unit for possible action.
Frequency *(of Analysis and Aggregation)*	Provider must submit CAP within 15 days; the approved CAP must be developed within 30 days of the date of discovery.

3. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

Requirement		Settings meet the home and community-based setting requirements as specified in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery		
	Discovery Evidence *(Performance Measure)*	PM: Number and percent of HBCS settings that meet Federal HCBS settings requirements. N: Number of HCBS settings that meet Federal HCBS settings requirements. D: Number of HCBS settings reviewed.
	Discovery Activity *(Source of Data & sample size)*	Data Source: Licensing/Certification visits conducted by OHA, HSD. Sampling Approach: 100% review of sites conducted at least biennially
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HSD Certification/ Licensing Unit and MPU
	Frequency	Biennially
Remediation		
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*		If provider is not in compliance with minimum requirements, provider must submit CAP. Non-compliance with approved CAP/ failure to develop an approved CAP will lead HSD to work with MHOs to seek alternate services and informing the License/ Cert Unit for possible action.
Frequency *(of Analysis and Aggregation)*		Provider must submit CAP within 15 days; the approved CAP must be developed within 30 days of the date of discovery.

4. The SMA retains authority and responsibility for program operations and oversight.

Requirement	**The SMA retains authority and responsibility for program operations and oversight**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of aggregated performance measure reports, trends, and remediation efforts reviewed by OHA. N: Number of aggregated performance measure reports, trends, and remediation efforts reviewed by OHA. D: Number of aggregated performance measure reports, trends, and remediation efforts generated by IQA. Number and percent of discovered deficiencies resolved by OHA. Numerator – number and percent of deficiencies resolved by OHA when discovered during quality assurance reviews; Denominator – total number of all reports with discovered deficiencies after quality assurance review by OHA.
Discovery Activity *(Source of Data & sample size)*	Data Source: Operating Agency Performance Review Sampling Approach: 100% of reports submitted to OHA by IQA
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HSD
Frequency	QTRLY
Remediation	
Remediation Responsibilities	Provide IQA with TA; review contract to ensure clarity of eligibility criteria
Frequency	within 15 days of the discovery of evidence

5. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

Requirement	The state maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers**.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims approved with appropriate plan of care as specified in the approved State Plan HCBS. N: Number of claims approved in accordance with the appropriate plan of care D: Total number of claims approved for files reviewed
Discovery Activity *(Source of Data & sample size)*	Data Source: Record Review – Off-site Sampling Approach: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology. OR MMIS contains many edits which are applied automatically to claims to prevent inappropriately issuing a payment. These edits include a Medicaid eligibility check, MHO enrollment verification, that a POC has been entered.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HSD
Frequency	ANNUALLY
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	100% of State Plan HCBS claims of participants that were not enrolled on the date of services are denied. Provide TA to providers on proper billing procedures and adjusting claims as needed
Frequency *(of Analysis and Aggregation)*	Within 90 days of the discovery of evidence

6. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

Requirement	The state identifies addresses and seeks to prevent incidents of abuse, neglect and exploitation, including the use of restraints
Discovery	
Discovery Evidence *(Performance Measure)*	(1) Number and percent of State Plan HCBS complaints resolved within required guidelines N: Number of complaints resolved within required guidelines D: Total number of complaints reviewed (2) Number and percent of allegations regarding wrongful restraint and involuntary seclusion where investigations are conducted in accordance with OAR407-045-0320 N: Number of allegations regarding wrongful restraint and involuntary seclusion where appropriate actions and follow-up occurred D: Total number of files reviewed that included allegations of wrongful restraint and involuntary seclusion. (3) HSD requires and ensures 100% of staff working in a RTF, RTH or AFH are trained by DHS OAAPI (or designee) in Mandatory Abuse Reporting. Number and percent of providers who meet abuse reporting training requirements ongoing N: Number of providers who meet abuse reporting training requirements ongoing D: Total number of providers reviewed (4) Number and percent of participants and/or guardians who are informed about the ways to identify and report abuse, neglect and exploitation N: Number of participants and/or guardians who are informed about the ways in which to identify and report abuse, neglect and exploitation D: Total number of files (5) Number and percent of incidents reports that were filed appropriately with OAAPI (timely and according to policies and procedures) N: Number of incident reports completed appropriately (timely and according to policies and procedures) D: Total number of files reviewed which contained initial incident

	Discovery Activity *(Source of Data & sample size)*	(1) CMHP submit QTRLY reports on Complaints. Will review for 1915(i) providers. (2) Immediate attention and response provided to receipt of call regarding a critical incident followed by a report via fax. (3) Data Source: Record Review – Off-site Sampling Approach: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	HSD
	Frequency	1) Annually 2) QTRLY 3) On-going 4) Annually

6. The state identifies (Cont)

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) If abuse cases are identified for specific provider agencies, HSD to review 100% of the residents' records of the identified provider agency to identify breadth of issue within 30 days. Provider must submit CAP within 15 days following completed review. Failure to make records available, non-compliance with approved CAP/failure to develop an approved CAP leads HSD/CMHP's to seek alternate services and informing the License/Cert Unit for action. (2) CMHP's submit QTRLY reports on complaints/grievances. HSD to review for 1915(i) related complaints/grievances. (3) Follow State protocol for any reported suspected occurrences of abuse, neglect or exploitation. HSD protocol is to forward any reported suspected abuse reports to State Office of Adult Abuse Prevention and Investigation (OAAPI) and partners with OAAPI on any supporting documentation needed. HSD receives ongoing status of any open cases by OAAPI and works in close partnership to ensure corrective actions are implemented. (4) HSD ensures 100% of staff working in an RTF, RTH, AFH are trained (by DHS OIT or designee) in Mandatory Abuse Reporting by requiring any staff not appropriately trained, receive the required training within 1 month of discovery.
Frequency *(of Analysis and Aggregation)*	1) Upon discovery of failure to meet any participants' health and welfare; 2) Follow-up and TA within 60 days of the date of discovery; 3) Immediately with any reported occurrence until process is complete. 4) Upon discovery of less than 100% of staff not receiving mandatory abuse reporting training

7. An evaluation for 1915(i) State Plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.

Requirement	**An evaluation for 1915(i) State Plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of participants who had an approved eligibility evaluation prior to enrollment. Numerator = Number of participants who had an approved eligibility evaluation prior to enrollment Denominator = Total number of participant files reviewed
Discovery Activity *(Source of Data & sample size)*	The majority of SPA performance measures are aggregated through queries from systems used to receive and process eligibility determination requests received by the Independent entity and by systems used to authorize services. Specific to eligibility evaluation measures Source of Data: Record Review - Offsite Sample Size: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The independent entity under contract with OHA will collect, store and produce reports for OHA that will contain the data specific to this requirement; (a) Total number of evaluations conducted during the quarter. (b) Total number of evaluations that meet HCBS eligibility criteria during the quarter.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The independent entity under contract with OHA will aggregate the data and provide reporting to OHA for review. OHA will provide remediation for identified reviews within 30 days of identification.
Frequency *(of Analysis and Aggregation)*	Annually

8. The processes and instruments described in the approved state plan for determining 1915(i) State Plan HCBS eligibility are applied appropriately

Requirement	**The processes and instruments described in the approved state plan for determining 1915(i) State Plan HCBS eligibility are applied appropriately**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of eligibility evaluations that were completed based on the instruments and processes in the approved State Plan. Numerator = Number of eligibility evaluations that were completed based on the instruments and processes in the approved State Plan. Denominator = Total number of eligibility evaluations reviewed
Discovery Activity *(Source of Data & sample size)*	The independent entity under contract with OHA will sample a representative group of completed (approved and denied) determinations. Source: Record Review – Off-site Sample Size: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The independent entity under contract with OHA will collect, store and produce reports for OHA that will contain the data specific to this requirement; (a) Total number of evaluations conducted during the quarter. (b) Total number of evaluations that meet HCBS eligibility criteria during the quarter. (c) Total number of evaluations that were determined to not meet HCBS eligibility criteria.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The independent entity under contract with OHA will aggregate the data and provide reporting to OHA for review. OHA will provide remediation for identified reviews within 30 days of identification
Frequency *(of Analysis and Aggregation)*	Annually

9. The 1915(i) State Plan HCBS eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS

Requirement	**The 1915(i) State Plan HCBS eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of participants who have a reevaluation of eligibility completed annually Numerator = Number of participants who have a reevaluation of eligibility that was completed annually D = Total number of participant files reviewed
Discovery Activity *(Source of Data & sample size)*	The independent entity under contract with OHA will sample a representative group of evaluations received that are due for annual redetermination. Source: Record Review – Off-site Sample Size: A representative sample using a 95% confidence interval, 5% margin of error and 50% distribution variable methodology.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	The independent entity under contract with OHA will collect, store and produce reports for OHA that will contain the data specific to this requirement; (d) Total number of participants due for an annual redetermination (e) Total number of participant evaluations received that were due for annual redetermination.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The independent entity under contract with OHA will aggregate the data and provide reporting to OHA for review. OHA will provide remediation for identified reviews within 30 days of identification.
Frequency *(of Analysis and Aggregation)*	Annually

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

HSD will gather the discovery evidence on a quarterly and annual basis to identify trends in each focus area on the QIS. HSD will also look closely for any trends specific to a residence or residential category. HSD will respond to findings in the manner that would be the most appropriate.

For example, if a statewide issue is identified, HSD would implement an intervention best suited for the issue, be it statewide trainings and technical assistance or targeting an intervention for a specific workforce such as the county residential specialists.

Another method to effect desired change will be to work with the HSD Licensing and Certification unit and their reviews to focus on identified areas for improvement.

The results of the data are public domain and participants may use it to inform their choice for one residence over another.

HSD will use the information gathered to determine what levels of care need more development, be it supported housing or strengthening interventions to promote independence.

HSD will prioritize the needs for system change by determining which areas for improvement will make the greatest improvement for the most participants in the program, furthering their level of independence.

2. Roles and Responsibilities

HSD: Administer IQA contract and monitor IQA for performance and outcomes. HSD will monitor processes of enrollment, payment, licensing for compliance, quality and outcomes. HSD will respond to reported deficits through compliance activities, rule application, post payment review of paid services and reporting to other accountable agencies when applicable.
IQA: Will implement person centered assessment and planning. Ensure implementation of person centered plans and report outcomes to HSD. Conduct medical appropriateness reviews of requested services. Ensure person centered planning guidelines are adhered to for authorized services. Gather and report QIS data for HSD.
LMHA / CMHP: Engage in processes for certification of providers. Monitor for health and safety. Provide technical assistance to providers and monitor for HCBS rule compliance.
Provider Agencies: Implement person centered plans. Deliver services. Maintain compliance with HCBS rules and Oregon Administrative Rule.
Participants: Participate in development of the person centered plan. Provide feedback to providers, CMHP and HSD.

3. Frequency

The HSD Licensing and Certification unit follow specific frequencies of monitoring that are defined in OARs.

- Outpatient Services: Certificates of Approval are valid for a maximum of 3 years;
- Residential Treatment Facilities & Homes: Licenses are valid for a maximum of 2 years; and
- Adult Foster Homes: Licenses are valid for a maximum of 1 year.
- Qualified Mental Health Professionals (QMHPs) are verified by the Local Mental Health Authority and MHO every 3 years.
- Qualified Mental Health Associates (QMHAs) are verified by the Local Mental Health Authority and MHO every 3 years.

Periodic or interim reviews can occur as needed when there is a concern about a program.

The other monitoring activities are defined within the QIS.
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4. Method for Evaluating Effectiveness of System Changes

HSD will contract with IQA to implement person centered planning, monitor outcomes, report compliance of contracted entities and collect data for use in the QIS strategy.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☑	HCBS Habilitation
	Payment methods for HCBS Habilitation use standard code sets such as CPT, HCPCS and modifiers. Existing Codes will be paired with the modifier "HW" to identify them as State Plan HCBS services. The agency uses a state-wide fee schedule that will update on 1/1/2017 and are applicable to services rendered on or after that date. The fee schedule is posted on the agency web at: http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of HCBS habilitative services. The provider types, can bill, depending on the services provided, in 15 minute units, daily or monthly frequency, accordingly to the CPT/HCPCS billing code utilized. HSD will periodically audit the providers to ensure the appropriateness of the rates. Rate reviews are conducted continuously and each provider will have a completed rate review at least every three years. All payments will be made retroactive based on submission of claim forms directly from OHA to the provider or to a third party administrator.

Methods and Standards for Establishing Payment Rates

☐	HCBS Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☑	HCBS Psychosocial Rehabilitation
		Payment methods for HCBS Psychosocial Rehabilitation use standard code sets such as CPT, HCPCS and modifiers. Existing Codes will be paired with the modifier "HW" to identify them as State Plan HCBS services. The agency uses a state-wide fee schedule that will update on 1/1/2017 and are applicable to services rendered on or after that date. The fee schedule is posted on the agency web at: http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of HCBS Psychosocial Rehabilitation services. The provider types, can bill, depending on the services provided, in 15 minute units, daily or monthly frequency, accordingly to the CPT/HCPCS billing code utilized. **Psychosocial Rehabilitation (PSR):** H2017 Psychosocial Rehabilitation 15-minutes; H2018 Psychosocial Rehabilitation Per-diem HSD will periodically audit the providers to ensure the appropriateness of the rates. Rate reviews are conducted continuously and each provider will have a completed rate review at least every three years. All payments will be made retroactive based on submission of claim forms directly from OHA to the provider or to a third party administrator.
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☐	Other Services (specify below)	