Table of Contents

State/Territory Name: Oregon

State Plan Amendment (SPA) #: OR- 25-0006

This file contains the following documents in the order listed:

1) Approval Letter
2) Form CMS-179
3) Approved SPA Page(s)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

December 22, 2025

Dr. Emma Sandoe
Medicaid Director
Oregon Health Authority
500 Summer Street Northeast, E-65
Salem, OR 97301-1079

RE: §1915(i) Home and Community-Based Services (HCBS) State Alan Amendment (SPA), OR-25-0006

Dear Dr. Sandoe:

The Centers for Medicare & Medicaid Services (CMS) is approving Oregon's request to amend its 1915(i) state plan home and community-based services (HCBS) benefit, transmittal number OR-25-0006. The effective date for this amendment is March 1, 2026. With this amendment, the state is modifying the name of the State's Medicaid Agency, Medical Assistance Unit, updating the assessment tool used for Performing Evaluations/Reevaluations and adding serious mental illness (SMI) to the target population criteria.

Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Attachment 3.1-i, pages 2, 8, 15, 26, 30, 33, 49 and 57-75
- Attachment 4.19-B, pages 44-47

CMS reminds the state that the state must have an approved spending plan in order to use the money realized from section 9817 of the ARP. Approval of this action does not constitute approval of the state's spending plan.

It is important to note that CMS' approval of this change to the state's 1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Carshena Harvin at Carshena.Harvin@cms.hhs.gov or (206) 615-2400.

Sincerely,

George P. Failla Jr -S

Digitally signed by George P. Failla Jr -S
Date: 2025.12.22 14:33:40 -05'00'

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

Enclosure

cc:
Donny Jardine, OHA
Kevin Patterson, CMS
James Moreth, CMS
Bill Vehrs, CMS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0006

2. STATE: OR

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~1/1/25~~ ~~6/1/25(P&I)~~ 3/1/26(P&I)

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 441 Subpart H, 1915(i) of the Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i, pages 2, 8, ~~13~~ 15,26,30,33,49,57-75(P&I)
Attachment 4.19-B, page 44-47

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i, pages 2, 8, ~~13~~ 15,26,30,33,49,57-65(P&I)
Attachment 4.19-B, page 44-47

9. SUBJECT OF AMENDMENT
This transmittal is being submitted to revise the 1915(i) state plan option. The revisions include new description of the assessment tool used, updating unit names, OAR citations, and replacing some older criteria with new criteria for certain conditions.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
Emma Sandoe

12. TYPED NAME
Emma Sandoe, PhD

13. TITLE
Medicaid Director

14. DATE SUBMITTED
2/26/25

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

ATTN: Jesse Anderson, State Plan Manager

FOR CMS USE ONLY

16. DATE RECEIVED
2/26/25

17. DATE APPROVED
12/22/2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
3/1/26

19. SIGNATURE OF APPROVING OFFICIAL
George P. Failla Jr -S
Digitally signed by George P. Failla Jr -S
Date: 2025.12.22 14:33:55 -05'00'

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Director, Division of HCBS Operations and Oversight

22. REMARKS
4/14/25: State authorized P&I change to box 4
11/19/25: State authorized P&I change to boxes 4,7 and 8.

Instructions on Back

	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)
☐	☐	**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)*:	Medicaid 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.	

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 an in-person assessment/reassessment with the individual, the individuals authorized or legal representative or guardian, if applicable, and in consultation with any other persons identified by the individual, such as, but not limited to, the spouses, family, friends, providers, and treating and consulting health and support professionals responsible for the individuals care to determine if an individual is eligible for 1915(i) HCBS services based on the diagnostic and needs-based criteria.

The tools utilized identify the individual's service and support needs is the interRAI. Completion of this tool, along with the IQA's review and consideration of all pertinent and necessary information, and consultation with the parties identified above result in the IQA's development of the individual's person-centered service plan.

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 or serious mental illness (SMI).

Pursuant to ORS 426.495 and Oregon Administrative Rule 410-173-0005, a person with a Serious and Persistent Mental Illness means an individual who meets the DSM-5 (or any futures updates to DSM) diagnostic criteria for at least one of the following conditions: Schizophrenia spectrum and other psychotic disorders, depressive disorders, bipolar and related disorders, Obsessive Compulsive Disorder (OCD), Post Traumatic Stress Disorder (PTSD) and Other Specified Trauma- and Stressor-Related Disorder due to cultural syndromes, or borderline personality disorder as diagnosed by a Qualified Practitioner pursuant to state law or a non medic al examiner certified by the Oregon Health Authority or the Oregon Department of Human Services. No conditions initially approved in this benefit will be removed.

☐ **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).

Community-Based Integrated Supports (Cont)

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):*
Licensed QMHP	State of Oregon Medical Board Oregon Board of Nursing Oregon Board of Psychology Oregon Board of Licensed Professional Counselors and Therapists Oregon Board of Licensed Social Workers Oregon Board of Licensed Social Workers as described in OAR 877-015-0105 Oregon Occupational Therapy Licensing Board	Every two years
Certified Behavioral Health Organization	Behavioral Health Division	Every three years
Enrolled In-Home Care Agency	OHA, Public Health Division	Annual
Service Delivery Method		
☐ Participant-directed	☑ Provider managed	

HCBS Residential Habilitation (Cont)

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):*
Mental Health Adult Foster Home	Behavioral Health Division	Every year
Residential Treatment Facility/Home	Behavioral Health Division	Every two years
APD and ODD Adult Foster Care	Local CDDPs, Branch offices and DHS Central Office	Annually
Residential Care Facility	DHS Client Care Monitoring Unit	Every two years
Assisted Living Facility	DHS Client Care Monitoring Unit	Every two years
Group Care Home and State Operated Group Homes for Adults	DHS Central Office	Biennially
Service Delivery Method		
☐ Participant-directed	☑ Provider managed	

HCBS Psychosocial Rehabilitation for individuals w CMI (Cont)

Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Certified Behavioral Health Organization	N/A	Organizational Certificate of Approval issued by the Health Systems Division as described in OAR chapter 309 division 8	Required to be Medicaid enrolled as a community 1915(i) plan provider.

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):*
Mental Health Adult Foster Home	Behavioral Health Division	Every year
Residential Treatment Facility/Home	Behavioral Health Division	Every two years
Residential Care Facility	ODHS Client Care Monitoring Unit	Every two years
Licensed Qualified Mental Health Provider	Behavioral Health Division	Every three years
Certified Behavioral Health Organization	Behavioral Health Division	Every three years
Additional needs-based criteria for receiving the service, if applicable *(specify):*		

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

(f) OHA will ensure reimbursement of services provided by relatives, legal guardians, and legally authorized representatives will only be made for services rendered by: requiring prior 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.

Relatives, legal guardians, and legally authorized representatives may provide specified services and are required to meet the provider qualifications set forth in Oregon Administrative Rule. Relatives, legal guardians, and legally authorized representatives may be paid when a conflict of interest is not present the relative meets the qualifications for the service provided and is chosen by the individual. Exceptions to this policy may only be granted by the Medicaid Division. Requests for exception must be submitted to the Medicaid Division. Requests should include a demonstration of effort to resolve any conflicts of interest through a thorough exploration of service setting options, a thorough exploration of available providers, and an inability to locate a qualified and willing designated representative.

Relatives may provide the services identified for which they meet provider qualifications, based on the individual's assessed needs and identified in the approved Person-Centered Service Plan. Services provided, regardless of the provider, must be in accordance with any limits identified in the waiver and set forth in OAR.

Relatives, legal guardians and legally authorized representatives who are identified as providers in the service plan are verified as being in the best interest of the individual by the individual, legal representative, or authorized representative, and case manager. Anyone identified as a provider, including relatives, legal guardians, and legally authorized representatives cannot be responsible for directing Person-Centered Service Plan development. When a legal guardian is paid to be a provider of 1915(i) services, another person must be designated as a representative for the purpose of developing the Person-Centered Service Plan.

All providers, including relatives, legal guardians, and legally authorized representatives provide services in accordance with authorized and signed Person-Centered Service Plan. All providers will record time and dates of services using the State's approved electronic visit verification system.

Service plans a) (Cont)

Requirement	**Service plans a) address assessed needs of 1915(i) participants;**
Discovery	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Medicaid MPU
Frequency	QTRLY
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) Contractor will conduct periodic review of performance measures to determine compliance with applicable Oregon Administrative Rules and the quality improvement strategy. (2) Reviews shall be conducted through onsite visit, face to face interview of Recipient or provider, document review, clinical documentation review or data analysis. (3) Data and reports related to performance measures and the quality improvement strategy submitted by the contractor are reviewed and analyzed by Medicaid to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Remediation activities may include targeted training and revision of administrative processes and procedures.
Frequency *(of Analysis and Aggregation)*	Contractor submits quarterly reports to Medicaid Division. Medicaid reviews and remediates on an annual basis. Individual remediation activities will require follow-up by Medicaid to determine that the corrective action was successfully completed. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Within 30 days of identification of need for plan of correction, IQA must agree to a plan of correction. Corrective actions include training and revision of administrative processes and procedures. Corrective actions will be completed within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff)

Requirement	Service plans b) are updated annually;
Discovery	
Discovery Evidence *(Performance Measure)*	(1) Number and percent of service plans that were revised/updated based on change in the individual's condition; N: Service plans revised/updated based on change in individuals' condition. D: Number of services plans reviewed. (2) Number and percent of service plans revised/updated within 12 months. N: Number of service plans that were updated/revised within 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)*	Medicaid MPU
Frequency	QTRLY
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) Contractor will conduct periodic review of performance measures to determine compliance with applicable Oregon Administrative Rules and the quality improvement strategy. (2) Reviews shall be conducted through onsite visit, face to face interview of individual or provider, document review, clinical documentation review or data analysis. (3) Data and reports related to performance measures and the quality improvement strategy submitted by the contractor are reviewed and analyzed by Medicaid to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Remediation activities may include targeted training and revision of administrative processes and procedures.

Service plans b) (Cont)

Remediation	
Frequency *(of Analysis and Aggregation)*	Contractor submits quarterly reports to the Medicaid Division. Medicaid reviews and remediates on an annual basis. Individual remediation activities will require follow-up by HSD to determine that the corrective action was successfully completed. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Within 30 days of identification of need for plan of correction, IQA must agree to a plan of correction. Corrective actions include training and revision of administrative processes and procedures. Corrective actions will be completed within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff)
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)*	Medicaid MPU
Frequency	Annually

Requirement	Service plans c) document choice of services and providers (Cont)
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) Contractor will conduct periodic review of performance measures to determine compliance with applicable Oregon Administrative Rules and the quality improvement strategy. (2) Reviews shall be conducted through onsite visit, face to face interview of individual or provider, document review, clinical documentation review or data analysis. (3) Data and reports related to performance measures and the quality improvement strategy submitted by the contractor are reviewed and analyzed by Medicaid to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Remediation activities may include targeted training and revision of administrative processes and procedures.
Frequency (of Analysis and Aggregation)	Contractor submits quarterly reports to the Medicaid Division. Medicaid Division reviews and remediates on an annual basis. Individual remediation activities will require follow-up by HSD to determine that the corrective action was successfully completed. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Within 30 days of identification of need for plan of correction, IQA must agree to a plan of correction. Corrective actions include training and revision of administrative processes and procedures. Corrective actions will be completed within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff)

2. Eligibility Requirements: (a) 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 (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS

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

Requirement		**Eligibility Requirements: (a) 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 files reviewed documenting individuals who have a reasonable indication of need for 1915(i) HCBS services have an evaluation for 1915(i) HCBS eligibility. N: Number of individuals who have a reasonable indication of need for 1915(i) HCBS services who are evaluated for 1915(i) eligibility. 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)*	Medicaid MPU
	Frequency	QRTLY

Eligibility Require6ents: (a) (Cont)

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	(1) Contractor will conduct periodic review of performance measures to determine compliance with applicable Oregon Administrative Rules and the quality improvement strategy. (2) Reviews shall be conducted through onsite visit, face to face interview of individual or provider, document review, clinical documentation review or data analysis. (3) Data and reports related to performance measures and the quality improvement strategy submitted by the contractor are reviewed and analyzed by the Medicaid Division to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Remediation activities may include targeted training and revision of administrative processes and procedures.
Frequency *(of Analysis and Aggregation)*	Contractor submits quarterly reports to the Medicaid Division. Medicaid reviews and remediates on an annual basis. Individual remediation activities will require follow-up by Medicaid to determine that the corrective action was successfully completed. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Within 30 days of identification of need for plan of correction, IQA must agree to a plan of correction. Corrective actions include training and revision of administrative processes and procedures. Corrective actions will be completed within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff).

Requirement		**Eligibility Requirements: (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately;**
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of files reviewed that document the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately. N: Files reviewed that document that eligibility is determined using the processes and instruments described in the approved state plan. 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)*	Medicaid MPU
	Frequency	QRTLY
Remediation		
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*		(1) Contractor will conduct periodic review of performance measures to determine compliance with applicable Oregon Administrative Rules and the quality improvement strategy. (2) Reviews shall be conducted through onsite visit, face to face interview of individual or provider, document review, clinical documentation review or data analysis. (3) Data and reports related to performance measures and the quality improvement strategy submitted by the contractor are reviewed and analyzed by the Medicaid Division to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Remediation activities may include targeted training and revision of administrative processes and procedures.

Eligibility Requirements: (b) (Cont)

Frequency *(of Analysis and Aggregation)*	Contractor submits quarterly reports to he Medicaid Division. Medicaid reviews and remediates on an annual basis. Individual remediation activities will require follow-up by the Medicaid Division to determine that the corrective action was successfully completed. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Within 30 days of identification of need for plan of correction, IQA must agree to a plan of correction. Corrective actions include training and revision of administrative processes and procedures. Corrective actions will be completed within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff)

Requirement		**Eligibility Requirements: (c) the 1915(i) benefit 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 individuals reevaluated for 1915(i) eligibility annually. N: Number and percent of individual files documenting annual reevaluation of 1915(i) eligibility. D: 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.

Eligibility Requirements: (c) (Cont)

	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Medicaid MPU
	Frequency	QRTLY
Remediation		
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*		(1) Contractor will conduct periodic review of performance measures to determine compliance with applicable Oregon Administrative Rules and the quality improvement strategy. (2) Reviews shall be conducted through onsite visit, face to face interview of individual or provider, document review, clinical documentation review or data analysis. (3) Data and reports related to performance measures and the quality improvement strategy submitted by the contractor are reviewed and analyzed by the Medicaid Division to identify areas of deficiency, required improvement and to assure completion of remediation efforts. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Remediation activities may include targeted training and revision of administrative processes and procedures.
Frequency *(of Analysis and Aggregation)*		Contractor submits quarterly reports to the Medicaid Division. Medicaid reviews and remediates on an annual basis. Individual remediation activities will require follow-up by Medicaid to determine that the corrective action was successfully completed. Non-compliance will be determined by any performance measure that falls below 86% accuracy. Within 30 days of identification of need for plan of correction, IQA must agree to a plan of correction. Corrective actions include training and revision of administrative processes and procedures. Corrective actions will be completed within 60 days of start of process (training completed, administrative processes/procedures revised and communicated to staff)

3. 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: Licensing/Certification visits conducted by OHA, Behavioral Health Division (BHD). Sampling Approach: 100% review of sites conducted at least biennially.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	BHD Licensing and Certification Unit for OHA licensed/certified providers Medicaid Division, Provider Enrollment Unit for non-licensed provider types, i.e Personal Care Attendants. ODHS, APD and ODDS licensing Units for ODHS licensed/certified residential providers.
Frequency	RTFs and RTHs reviewed every 2 years, AFHs reviewed every year. Non-licensed providers reviewed every two years for background check and every 5 years for all other requirements.
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 take corrective action. Non-compliance with approved corrective action will lead BHD to work with MHOs to seek alternate services and informing the License/ Cert Unit for possible action.
Frequency *(of Analysis and Aggregation)*	Provider must take corrective action and notify BHD of completion of corrective action within time frames specified in the notice of violation as described in licensing rules for the setting.

4. 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, BHD. Licensing/Certification visits conducted by ODHS, APD and ODDS for settings licensed/certified by ODHS. Sampling Approach: 100% review of sites conducted at least biennially
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	BHD Certification/ Licensing Unit and MPU ODHS, APD and ODDS licensing and certification units.
	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 take corrective action. Non-compliance with approved corrective action will lead BHD to work with community mental health organizations to seek alternate services and informing the License/ Cert Unit for possible action.
Frequency *(of Analysis and Aggregation)*		Provider must make corrective action and notify BHD of completion of corrective action within time frames specified in the notice of violation as described in licensing rules for the setting.

5. 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)*	Medicaid Division
Frequency	Annually
Remediation	
Remediation Responsibilities	Provide IQA with TA; review contract to ensure clarity of eligibility criteria
Frequency	within 15 days of the discovery of evidence

6. 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)*	(1) 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. (2) Number and percent of claims paid for services furnished by qualified providers. N: Paid claims furnished by qualified providers. D: Total paid claims reviewed
Discovery Activity *(Source of Data & sample size)*	Data Source: Record Review – On-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 referring, billing and performing provider checks, prior authorization check (including POC) and diagnoses check.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Medicaid Division
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

7. 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 OAR chapter 419 division 110 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) Medicaid Division and BHD requires and ensures 100% of staff working in a RTF, RTH or AFH are trained 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 (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.

The state identifies, addresses, and seeks …(Cont)

	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 (applies to all five PM above) 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)*	Medicaid Division
	Frequency	QTRLY

The state identifies, addresses, and seeks …(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, OHA 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 OHA/CMHP's to seek alternate services and informing the License/Cert Unit for action. (2) CMHP's submit QTRLY reports on complaints/grievances. BHD to review for 1915(i) related complaints/grievances. (3) Follow State protocol for any reported suspected occurrences of abuse, neglect or exploitation. BHD 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. OHA receives ongoing status of any open cases by OAAPI and works in close partnership to ensure corrective actions are implemented. (4) BHD ensures 100% of staff working in an RTF, RTH, AFH are trained (by ODHS 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.

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

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

For example, if a statewide issue is identified, Medicaid 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 BHD Licensing and Certification and/or the Medicaid Provider Enrollment 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.

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

Medicaid Division 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

Medicaid Division: Administer IQA contract and monitor IQA for performance and outcomes. Medicaid Division will monitor processes of enrollment, payment, licensing for compliance, quality and outcomes. Medicaid Division will respond to reported deficits through compliance activities, rule application, post payment review of paid services and reporting to other accountable agencies when applicable.
BHD: Conduct licensing and certification activities and monitor for compliance with HCBS rules in OAR chapter 309 Divisions 019, 035, and 040. BHD will respond to deficits identified through compliance activities and rule application.
IQA: Will implement person centered assessment and planning. Ensure implementation of person-centered plans and report outcomes to the Medicaid Division. Conduct medical appropriateness reviews of requested services. Ensure person centered planning guidelines are adhered to for authorized services. Gather and report QIS data for Medicaid Division.
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, Medicaid Division and BHD.

3. Frequency

The BHD 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 and Medicaid Provider Enrollment revalidates enrollments every five years;
- Residential Treatment Facilities & Homes: Licenses are valid for a maximum of 2 years and Medicaid Provider Enrollment revalidates enrollments every five years;
- Adult Foster Homes: Licenses are valid for a maximum of 1 year and Medicaid Provider Enrollment revalidates enrollments every five years;

Qualified Mental Health Professionals (QMHPs) are verified by the BHD Licensing and Certification Unit every 3 years and Medicaid Provider Enrollment revalidates enrollments every five 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.

4. Method for Evaluating Effectiveness of System Changes

The Medicaid Division 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

☑ HCBS Habilitation (Cont)

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

  An individual's assessed needs determine the rate as negotiated in the collective bargaining agreement. For individuals enrolled in 1915(i) services, the level of need is determined through interRAI assessment tool, along with consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records determine the level of need.

Payment for services provided in the following DHS-licensed/certified community-based residential settings will be made using the approved rate methodology for services provided in these settings under the 1915(k) Community First State Plan Option and as described below:

- Assisted Living Facility - Assisted Living Facility rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Assisted Living Facilities rates are paid based on the individual's assessed needs. An Independent and Qualified Agent conducts the needs assessment using the interRAI assessment tools in consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records. The individual's needs result in a reimbursement in one of 5 payment levels. The different payment levels reflect the individual's acuity and ADL needs as follows:
  - Level 1 - All individuals qualify for Level 1 or greater.
  - Level 2 - Individual requires assistance in cognition/behavior AND elimination or mobility or eating.
  - Level 3 - Individual requires assistance in four to six activities of daily living OR requires assistance in elimination, eating and cognition/behavior.
  - Level 4 - Individual is full assist in one or two activities of daily living OR requires assistance in four to six activities of daily living plus assistance in cognition/behavior.

Methods and Standards for Establishing Payment Rates

☑ HCBS Habilitation (Cont)

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

- Group Care Homes for Adults - Each individual's support needs be assessed using a functional needs assessment annually, when an individual request's it or when the individual's needs change. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual person-centered planning meetings, and when there are changes to the person's condition:
  - The functional needs assessment collects information about the person's support needs. This information is used to match the individual with one of several levels of expected support need. For individuals enrolled in1915(i), interRAI assessment tools, along with consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records will substitute for the ODDS functional needs assessment.
  - A funding tier is assigned. Each funding tier corresponds to the functional needs assessment derived expected support levels.
  - Each funding tier contains several rates that reflect appropriate funding for a person with that particular level of support need, adjusted by the size of setting (licensed capacity) in which they reside.

- State Operated Group Care Homes for Adults - Each individual's support needs are assessed using a functional needs assessment. For individuals enrolled in 1915(i) services, interRAI assessment tools, in consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records will substitute for the ODDS functional needs assessment. Changes in an individual's support needs may be identified during regularly scheduled monitoring visits, annual eligibility redeterminations, annual person-centered service plan meetings, and when there are changes to the person's condition.

Methods and Standards for Establishing Payment Rates

☑ HCBS Habilitation (Cont)

- State Operated Group Care Homes for Adults – (Cont) The rate setting methodology incorporates other payroll expenditures (OPE), allowable administration percentages, and other costs associated with operating a business. It also incorporates information on revenue and expenses about the service so that DHS and OHA can assure that the total funding does not exceed the cost of operating the site.
- Residential Care Facility Regular - Residential Care Facility (Regular) rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Residential Care Facilities are paid a base rate with add-ons for specific medical, behavioral and ADL needs. For individuals enrolled in 1915(i) services, interRAI assessment tools, in consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records will substitute for the APD functional needs assessment to determine the base rate and any potential add-ons. The reimbursement rate may include the base rate with up to three add-on payments. Add-ons are paid if:
  - (A) The individual is full assist in mobility or eating or elimination;
  - (B) The individual demonstrates behaviors that pose a risk to the individual or to others and the provider must consistently intervene to supervise or redirect; or
  - (C) The individual's medical treatments, as documented in the needs assessment, require daily observation and monitoring with oversight by a licensed healthcare professional, no less than quarterly, and the facility has trained staff to provide such service and does provide the service.

- Residential Care Facility Contract - Residential Care Facility (Contract) rates are established based upon market conditions designed to assure adequate access to services for beneficiaries. Contracted rates are established for providers targeting a specific population and negotiating a specific rate for services provided to any individual within that target population. There are two types of contracted rates:
  - Supplemented Program Contract (as referred to in 1915(k) state plan): Allows an enhanced rate for additional services in excess of the published rate schedule to providers in return for additional services delivered to target populations.

Methods and Standards for Establishing Payment Rates

☑	HCBS Habilitation (Cont)

- Residential Care Facility Contract – (Cont)
  - Residential Care Facility Specific Needs Setting Contract: A specific needs setting contract pays a rate in excess of the published rate schedule to providers who care for a group of individuals whose service needs exceed the service needs encompassed in the base payment and all add-ons. The provider must show the additional costs associated with providing care to the target population.

- APD Adult Foster Care - Medicaid reimbursement rates for Adult Foster Home providers are collectively bargained through the Department of Administrative Services on behalf of the Department of Human Services with the Service Employees International Union. These rates are set based on a bargaining agreement at two-year intervals. The collective bargaining process is a public process. An individual's assessed needs determine the rate as negotiated in the collective bargaining agreement. For individuals enrolled in 1915(i) services, interRAI assessment tools, in consultation with health and support professionals responsible for the individuals care, and reviews of clinical and treatment records determine the level of need.

  Except as otherwise noted in the plan, state-developed fee methodology 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.

☐	HCBS Respite Care