1115 Questions and Answers (Updated January 10, 2022)

Note: *This document will be updated frequently as more questions and answers are added. Additional questions can be sent to the APD Medicaid Policy mailbox at apd.medicaidpolicy@odhsoha.oregon.gov*

Contents

AAA-APD Coordination

Are there APD position descriptions for OPI-M & FCAP?

Current position descriptions are being updated to add work related to OPI-M. It is not expected that there will be substantial changes to the current descriptions. Language has been drafted and the position description changes are in the process of review. They will be shared when ready.

What are the roles of the APD and AAA staff?

For areas served by a Type B AAA, the AAA staff will handle both OPI-M/FCAP Eligibility Case Management and Services Case Management. Type B AAAs will decide how to staff these responsibilities while avoiding conflicts of interest.

In areas where there is an APD office and a Type A AAA, APD staff will complete the initial and annual determinations for financial and service eligibility. They will assist the consumer in the choice of OPI-M or FCAP (and any other programs for which they are eligible) and refer to the AAA for service planning. This role of determining eligibility will be handled by the "Eligibility Case Manager" (ECM).

The Type A AAA staff will work with the consumer to develop a service plan, identify a provider, set up payments, assess and monitor for risks, complete direct and indirect contacts, adjust service plans as needed and complete other tasks of ongoing case management. This role is called the "Services Case Manager" (SCM),

What type of notices will AAAs be required to send? Are those the same as the current SPANs? What will the APD offices send? Will training be provided about notices?

The AAAs will be required to send the new service plan which will also serve as the notice. A document is being developed by Central Office that will explain required notices to be written by eligibility and those to be completed by service case managers. The document will be posted on the CM Tools website once completed. OPI-M/FCAP Notice Training will be provided.

If the ECMs will be completing the SPANs, but the SCMs service plan, will the SPAN be changing for OPI-M cases? Our current SPANs require entering how many hours were applied per category, if an exception was approved, etc. which the ECM would not have until the SCM service planned.

No changes will be made to current SPAN, and it will not be used for OPI-M or FCAP. If consumer is eligible for traditional Mediciad LTSS benefits but chooses to apply for OPI-M or FCAP the SPAN will not be required so long as the consumer completes a 457D. As noted in the previous question, Central Office is developing a document to explain notice requirements and it will include information about the SPAN and when it is required. The SCM will complete the service planning form for OPI-M/FCAP.

If there is a reassessment with a denial for LTC but approval for OPI-M who completes the SPAN denial? What if it is a denial for all programs?

It will still be an ECM sending a SPAN for denial. The ECM would fill out 457D if the consumer is requesting OPI-M only.

Will OPI-M launch before FCAP?

Yes, OPI-M will launch first. The opening will be a soft launch, notifying current OPI consumers that OPI-M is starting, that current consumers will be auto-enrolled and giving them the option to opt out of OPI-M and remain on traditional OPI. FCAP, along with new consumers applying for OPI-M, is anticipated to begin approximately 60 days after the soft launch starts.

Where/how/when does Options Counseling fit in to the flow chart? Shouldn't Options Counseling start every referral so that all programs and services are explored at the beginning?

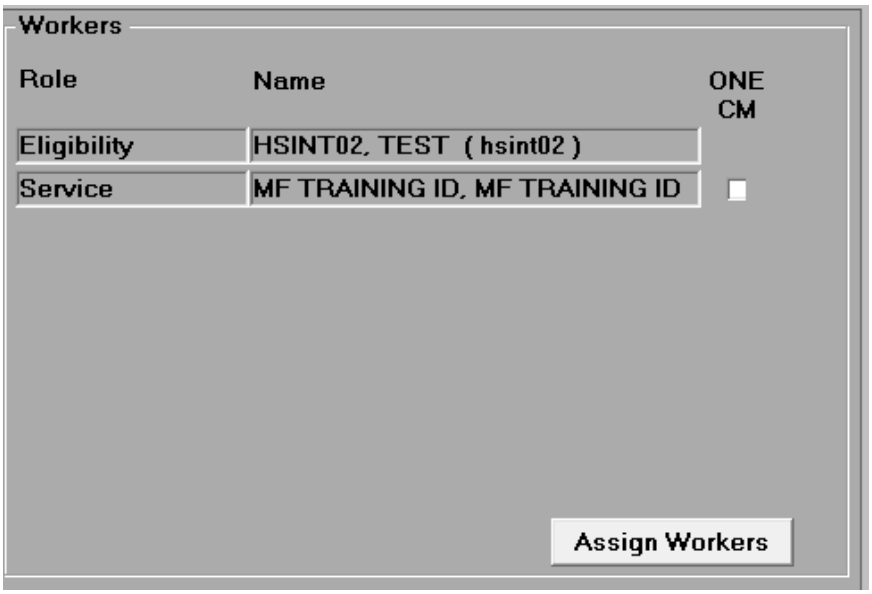
Options counseling will occur as per current policies and protocols, depending on the protocols of an APD office or at the ADRC.

Will the APD office or the type A AAA hold the case once initial eligibility is determined?

The case will be held by APD until eligibility is determined, and then transferred to a Type A AAA. The case should then remain with the Type A AAA. For areas with Type B AAAs, they will open and keep the case.

How will workers be assigned roles on the consumer's Oregon ACCESS record? If the case is held by the AAA, can an APD eligibility case manager still be on the case record as a case manager or eligibility case manager?

How workers are assigned may very by office. Some APD offices have expressed they will have individual ECMs assigned to cases and others have discussed the use of a banked case load model. It's possible, in Oregon ACCESS, to have both the ECM and SCM assigned to the case. For example, if the ECMs name is Test and the SCM name is MF TRAINING ID then the assigned workers may look like the image below (a bank case load may look slightly different).



Will it be necessary to transfer cases between branches, or is it possible for case managers to have access to multiple branches so they won't have to go through the process of transferring cases? One AAA stated it would be preferred to keep the cases at their branch.

Once a consumer is eligible and has chosen OPI-M or FCAP, their case will be transferred from the APD office to the Type A AAA office, where it will remain**.** For Type B AAAs, cases will not need to be transferred for eligibility determination and service planning.

How are referrals going to work? Right now, referrals for OPI are coming in the ADRC.

Referrals will come through different sources. One source is through the ADRC, as current OPI referrals are done. A second source is through the ONE system, where an applicant will be screened for all programs, and if denied for traditional Medicaid they will be reviewed for OPI-M/FCAP. In the ONE system, an individual

may be denied for being over resource or over income. To ensure individuals are not being missed, the denial report will be reviewed by a Central Office team. Individuals found on the report who need to be reviewed for OPI-M/FCAP will be identified. An email will then be sent to the local office with the individual's information and a request that they be contacted to determine if the individual wishes to be reviewed for OPI-M/FCAP.

Has or will Central Office create sample templates? For example, for when a consumer has been approved/denied by APD and APD is transferring the file to the AAA, when APD is referring back to the AAA for regular OPI or ADRC help, when the AAA is referring to APD for the annual eligibility assessments or other common situations

All areas with Type A AAAs and APD are being encouraged and assisted to create local referral templates for coordination between the APD and AAA offices. Please connect with your local management about the collaboration between the APD and AAA offices in your area and what local processes have been created. If additional support is needed, management may contact the APD policy email above if your area needs additional guidance.

Transition to OPI-M and Waitlist

Will case manager contact information be in the opt out letters and will consumers be directed to contact their current case manager with any questions?

No, contact information for individual case managers will not be included in opt out letters. The letters will include general contact information for the AAA.

How does the OPI waitlist and county budget work with the APD process?

State & Federal Medicaid funds will be used for OPI-M which support more people being served and the end of waitlists. AAAs will continue to receive some, but more limited funding to serve people who are ineligible for OPI-M/FCAP or prefer traditional OPI.

Is there an option not to do the soft launch and the full rollout at the same time and if so, can we advocate for that? It is overwhelming.

The plan is to do the soft launch for OPI-M prior to the public launch; both the soft and public launch will proceed statewide.

Can the local AAA send out the opt out letters or do they have to come from the state? The AAA shared with me that it would be significantly better for them to come from the AAA to avoid as much confusion as possible.

The mailing needs to be carefully timed and statewide. APD can handle and pay for the statewide mailing. Local AAA contact information will be included in the opt out letter.

Should the AAAs not admit any new OPI cases until full launch?

AAAs can continue to add new OPI cases if they have the budget to do so.

How will the current wait list be handled?

People on the wait list will be screened after the program opening but not during the soft launch.

It is yet to be determined and under consideration if individuals with the highest need will be prioritized.

How will folks know they have the option of OPI regular or OPI-M?

There will be lots of communication and outreach to notify community members, partners, providers, advocates and the public about the new program and service options. There will be training for AAA and APD staff so that both programs are included in discussions about service options.

What is expected to be the intake workload when the program starts?

It is anticipated that the workload will rise over time as partners and consumers become aware of the new programs. The initial soft launch will be done primarily behind the scenes with minimal local office impact.

Eligibility Process

Who will do the financial eligibility for OPI-M and FCAP?

The Eligibility Case Manager, from either the APD office or the Type B AAA completes financial eligibility for both initial and annual financial eligibility reviews.

If someone is denied in ONE, will Central Office screen for eligibility? If not, who?

Central Office will review the denial report from ONE to identify potential cases that need additional review for OPI-M/FCAP. Cases will then be sent to APD/Type B Medicaid staff to contact the individual and to determine if they interested and if they are eligible for OPI-M and FCAP.

Will all cases go through ONE?

It is strongly encouraged that all applicants go through ONE so they can be screened for all available programs (and for ease of using the automatic verification system (AVS)). However, if an applicant does not want to do that, APD would and could not force them to apply. In a situation in which they did not wish to apply through ONE, the office would need to process the request manually. Regardless of whether ONE is used or not, staff will need to put financial information in OR Access and on the OPI-M/FCAP application form. More information and training will be provided when available.

Will ECMs be given access to the former AVS system, outside of ONE or will a case need to be created in ONE for each OPI-M applicant regardless of the origin of the request?

Formerly, there was a portal to access AVS prior to ONE. Work has already begun to reestablish access to AVS web portal. Depending on what service is requested initially, AVS or AVS through ONE will be used.

Will there be a cap on the number of participants in the programs?

No, there is no cap in either program. These are Medicaid programs: Medicaid does not allow waitlists.

How will the APD offices know which consumers are due for their annual re-assessments? Is there a way they can track without waiting to hear for the AAA?

APD & AAAs will be able to generate a report through Oregon ACCESS of consumers due for reassessments.

May we have a document that provides an explanation and any guidance on how SSP and the VECs will handle OPI-M screening? Will they do OPI-M screening? If not, how will we know when APD or the Type B AAA needs to do so? for example if they determine someone is over income for regular Medicaid.

APD's CCU will pull from denial lists any cases that may potentially be eligible for OPI-M or FCAP and send an email to the APD or Type B AAA for follow up.

May we have list of what the Eligibility CM does to "complete the case" as on the flow chart? What exactly does mean? Upload to EDMS, push assessment to current, notice? other?

Flow charts summarize the work process. Offices may have their own workflows of which staff cover specific tasks. Regional meetings are taking place for each area to develop its own specific workflows and tools. Central Office can provide technical assistance as needed. Generally, completing a case includes but is not limited to these tasks: financial eligibility has been determined, a CA/PS assessment has been completed and within Oregon ACCESS, pushed to complete, the consumer has been notified of the eligibility decision, notifications have been completed and sent, Oregon ACCESS narration has been completed and all documentation has been uploaded to EDMS. In the areas where an APD office and a Type A AAA are involved, local processes around case coordination must also be followed.

Is there a timeframe for APD to tell consumers when the AAA will contact them about services and service planning?

The expectation is that the AAA will contact the consumer within 14 days after eligibility is determined and the case is transferred. At a minimum, the work must be completed in time to meet the 45 day application processing time frame as specified in Oregon administrative rule.

What happens if the person is determined no longer eligible at re-assessment?

A determination notice with hearing rights will be sent to the consumer, the person will be screened for other programs and an options counseling referral offered to the consumer via ADRC.

Will there be a denial that is sent to folks that could meet SPL for LTSS but are electing to go with OPI-M or FCAP?

If an individual is eligible for LTSS but chooses OPI-M or FCAP then a SPAN notice is not required if the consumer signs a 457D, waiving their LTSS option.

It sounds like if they're over income, they're over income and there's nothing like an income cap trust, is that correct?

That is correct. The OPI-M/FCAP eligibility rules specify that an income cap trust will not be allowed for these programs.

So, to be clear, if someone is interested in OPI-M and SNAP or other programs they will need to do eligibility with an eligibility case manager and a regular eligibility worker?

SNAP eligibility must be done in ONE. Once financial information is captured there, it can also be used to determine OPI-M/FCAP financial eligibility. Two workers will be necessary: one for the SNAP benefits and one to process the request for OPI-M/FCAP. The OPI-M/FCAP Eligibility Case Manager will pull the financial information from ONE and enter it into Oregon ACCESS and then proceed with the OPI-M/FCAP eligibility determination.

In the training it stated no one under 60 for OPI but then said MED referral would be needed for people under 60 with these indicators. Will MED referrals be required for 60 and under for OPI-M clients like we do MED referrals for APD clients who are under 65? If so, will the MED referrals be the same?

People under age 60 with a diagnosis of a mental or emotional disorder or substance abuse related disorder must meet the physical disability criteria in the OPI-M/FCAP eligibility rules. The MED process must be used to determine whether the need for services is based on a non-psychiatric diagnosis or physical disability.

If we have a client who qualifies for OPI-M and the spouse already receives regular OPI, will this affect the client's eligibility for OPI-M?

For OPI, both the applicant and their spouse's income are used in eligibility determinations. For OPI-M, only the applicant's income is considered. All of the couple's resources are considered in eligibility for both programs.

If someone has a recent service assessment in which their level of care did not qualify them for Medicaid Long-Term Care services, will they be able to apply directly for OPI-M, and if so, who would handle that reapplication? Or would the individual need to restart the process from the beginning and wait for a new service assessment and eligibility determination?

The consumer should be presented with OPI-M as an option and assessed for OPI-M eligibility by an ECM. If a person was already denied, then the person will need to apply for OPI-M/FCAP as a new applicant. If there is existing financial and service information from the previous application and it is within 30 days of the new request, it may be reviewed, updated and used to determine eligibility for the current request.

Can one have both Family Caregiver Assistance Program and Family Caregiver Support Program?

No, that would be a duplication of services which is not allowed.

Why can't people in Healthier Oregon qualify for OPI-M and FCAP?

OPI-M and FCAP are intended for people who some in-home support to maintain their health and well-being. It is intended to prevent the need for a full service package that includes medical benefits.

Will there be a whole new application exclusively for OPI-M/FCAP or will we revert to the 539A? When you say application do you mean a computer application?

We are not reverting back to 539A. A new application is under development. The application will be available as a document online and in printed form.

Are Buckley notices going to be required for OPI-M?

Yes, these notices will be required.

Can you explain in more detail what SPL 1 to 18 means?

SPL stands for service priority level and is based on needs for assistance in activities of daily living. SPL is used to determine service eligibility. Levels 1-18 are described in Oregon Administrative Rules, Chapter 411, Division 015. SPL training is available in Workday and there are SPL resources and information on the CM Staff Tools page.

Will there be hearings rights for those closed or denied? Whose role is to participate in the hearings?

Yes, there are hearing rights. The roles in hearings may vary based on circumstances (eligibility or services, depending on the topic of the issue). A guidance document is being developed.

What appeal process will consumers have?

Consumers will have hearing rights as for other Medicaid programs. Rights include appeals on eligibility determinations, handled by the Medicaid Eligibility Case Manager and service plans handled by the Services Case Manager.

Service Case Management

Does service have to be provided within 14 days from eligibility determination?

No – this is a waivered service. As long as the individual is eligible, they stay eligible.

If the consumer chooses to complete the financials outside of ONE, what is the process for pulling reports and information to complete renewals? Are we just assuming that we will renew based on the service planning dates?

Financial and service renewal dates should remain the same and not differ, especially since there is no longer a requirement for change in condition assessments. The CAPS 2 Assessment Review Report can be utilized to find out when renewals are due.

If there is a change of condition mid-year, does the APD CM have to do a new assessment or can AAA CM do it mid-year?

New assessments are not required for a change in condition unless the changes are so significant that the person might no longer be eligible. Assessments are used to determine service eligibility. The APD or Type B AAA Eligibility Case

Manager handles all service assessments. If there is a change in condition and the person is likely to remain eligible, the Type A or Type B AAA Services Case Manager works with the consumer to determine the new needs, revises the service planning form, narrates in Oregon ACCESS and adjusts the service authorizations as needed.

Are there caps on number of hours of services? If so, what is it?

For Homecare Worker hours, there is a cap of 40 hours every 2 weeks for OPI-M, exceptions may be requested.

What about the exception process, who does and how does it get approved? What about hearing process?

Exceptions will be requested by the Services Case Manager as part of the service planning process. Exceptions are sent to APD Central Office for review and a decision. Form 514i will be used to write and submit exception requests. OPI-M exceptions policy can be found in the OPI-M rules. There are no exceptions in FCAP. The exceptions section of the CM website has material to assist workers in preparing exceptions.

Consumers may request hearings on exceptions. Central Office provides the decision to the local office. The Services Case Manager sends the notice which has the hearing rights information.

How should disagreements about the assessment between eligibility CM and service CM be handled?

The purpose of the assessment is to determine eligibility. If the Services Case Manager does not agree with the eligibility decision, the SCM may present additional information for consideration to the Eligibility Case Manager. Supervisors and Central Office may assist if needed. If the consumer is already receiving services and the SCM believes the consumer is no longer eligible, the SCM should refer the situation for a re-assessment. The ECM and SCM should work as a team to best serve the consumer and follow program rules.

How will AAA documents and materials for the file be uploaded to EDMS? Do we know if the AAAs will have access to EDMS? If so, do we know when access to EDMS will be granted to AAAs?

AAAs will be given access to upload files to EDMS; the timeline on when AAAs will have access is to be determined. Until that time AAAs will continue to utilize their current document retention practices. The new OPI-M/FCAP service plan form does require the ability to be saved digitally. Offices will need to develop an internal process for saving these copies. If assistance is needed, management can reach out to Central Office for guidance.

Do/does AAA need access to Collective (to see if a consumer has been admitted to ER/hospital)?

There is no current Collective mandatory use policy at this time. Over time, Type A AAAs will be given access to Collective for use in work with OPI-M and FCAP consumers. Best practice is for Collective to be checked when completing risk assessments and service planning for Medicaid eligible consumers receiving services. Information on traditional OPI and other Type A AAA consumers is not available in Collective.

Our AAA has never used Oregon ACCESS ticklers. It sounds like that would be helpful so that we could see if APD staff has been involved. Where can we find training on Oregon ACCESS ticklers?

Information on the creation and use of Oregon ACCESS ticklers will be added to the OPI-M/FCAP section of the CM Tools website.

Is the AAA expected to do a new service plan if the consumer is re-assessed and it is determined they are still eligible?

If the needs have not changed and the consumer does not opt for a new service plan, the plan may remain unchanged but must at least be reviewed by the consumer and SCM. The practice is to have a consumer and person-centered service planning process. The review and determination to stick with the current plan should be documented.

What happens if a client reports a change to income or resources throughout the recertification year? Would it go back to eligibility CM or can services CM handle that portion?

All of the financial review or eligibility determination is handled by the eligibility case manager. If financial information is reported in mid cert and is shared with the services case manager, it will need to be relayed over to the eligibility case manager for review. The ECM should review this information and narrate the review in the consumers Oregon ACCESS case. However, if the new information is not going to impact their eligibility, such as their income is not going to exceed the new income limits or resources won't exceed the new resource limits, no action will be required on the case.

It doesn't make sense for the ongoing case manager to do the risk assessment. It seems like a duplication of efforts, those were revealed during the original assessment.

For OPI-M and FCAP, the service plan and risk assessment are completed by the service case manager only after the individual has chosen OPI-M or FCAP. It is possible that a risk assessment could be done before OPI-M or FCAP is chosen. If this were to occur, the service case manager would review the risk assessment and ensure it aligns with the new service plan for OPI-M and FCAP.

Just to clarify. The hours aren’t subject to two-consumer household?

For OPI-M and FCAP, we're looking at services on an individual basis. For two consumers in the same home, we would assess them separately and determine their care needs and the service plan would reflect their needs independent of each other.

Would a case manager continue to case manage a case after a home modification occurred or a muck out of a home, if they didn't want to hire a caregiver?

Yes, quarterly contact would still be required as long as the consumer still wanted to be on OPI-M or FCAP. If someone is assessed as a high risk from their risk assessment, there contacts could be monthly. If there is only a minimal need (such as a modification or deep clean) for the individual to remain independent,

the person may choose to withdraw from the program. The programs are intended to provide minimal services to support an individual's independence.

Would the authorization of hours be decided by the services case manager?

The service plan will be completed with the consumer and the services case manager. Hours will be decided based on assessed need and consumer input. The services case manager will be responsible for entering the authorized services and hours into the Oregon ACCESS service plan.

Will the OPI-M case manager be doing the requests for K-plan and exceptions or the APD services case manager?

Requests and exceptions will be part of the SCMs responsibilities during discussion of services and supports with consumers. OPI-M is different than the K-Plan although there are similar benefits and services on each program. The K-Plan is a full Medicaid LTSS plan which includes health insurance coverage.

Several agencies will be having their options counselors do FCAP. Is CAPS training sufficient?

No. FCAP is going to have its own separate training module that will talk about the various services available through FCAP – such as what services are available, how to service plan, and how to complete the family caregiver assessment tool. The CAPS assessment training will not cover all that workers need to know about FCAP. If an Options Counselor is going to assess for or be the Services Case Manager for a consumer receiving FCAP, the Options Counselor must meet the criteria for Services Case Managers and be trained in FCAP Service Case Management.

Will there be an easy way in the system to tell which OPI program consumers are on?

Changes are being made to Oregon ACCESS to identify and separate OPI-M, FCAP and OPI programs.

If, at some point, the consumer who meets SPL 1-13 initially choses OPI-M but later decides to choose APD services, if the assessment is still valid, would they require another reassessment?

Yes, a new assessment and financial eligibility would need to be completed because it's a different program with different eligibility requirements.

Provider Payment

Which branch will the ongoing case be carried in (AAA or APD) and how does this impact voucher payment and process, including PTC?

The AAA will hold the case in their branch and process all provider payments, including HCW payments via PTC.

What will the workload look like for the Voucher Clerk?

The workload will increase as the programs grow and more consumers are being served.

What are the payment process systems for all provider types, including HCWs?

HCWs will continue to use OR PTC DCI but the OPI-M or FCAP benefit code will need to be selected. Other provider payment processes are still in development.

Will OPI-M use in home care agencies, if yes, who will enter payment information into MMIS?

Yes, OPI-M will use in home care agencies. The AAA will enter the payments. Rights are being granted in MMIS. The plan is for OPI-M in home agency billing to also be processed through MMIS however that is not possible just yet as systems work needs to be completed first. The systems work is unlikely to be ready when OPI-M rolls out so there is a plan to have a system of invoicing. The invoicing details are in process and there will be training when the process

and any forms are finalized. There will also be training when the MMIS system can process OPI-M billing.

What happens to AAA contracts with in-home agencies? Will in-home agencies lose business or be in jeopardy of going out of business if there are fewer OPI consumers to serve?

Current contracts can remain in place and continue to serve OPI consumers. While there is likely to be a reduction in people receiving OPI services, it is expected there will be demand for OPI-M services. In-home care agencies with Medicaid provider numbers can provide services to OPI-M consumers. It's important to remember that it is the individual's choice of who provides services. The consumer can choose an in-home agency or a HCW.

If an OPI-M consumer gets Home Delivered Meals, how is that paid?

Medicaid is the primary payor. Central Office will share the billing method, including training and technical assistance for those who are not familiar with how HDM is currently paid for Medicaid recipients.

Will OPI-M consumers be able to use all Medicaid In-Home Care agencies and Long Term Care Community Nurses in our area that APD consumers have been able to utilize?

Yes, Medicaid funding means that Medicaid providers can be used.

Are we still thinking about a fiscal intermediary for FCAP?

Yes. Discussions are in progress and that is the current intent although fiscal intermediaries may not be in place when FCAP opens. Central Office will provide information when it is available.

May we have training and documentation on how to pay all the various providers? Will there be vouchers for some? MMIS? Other systems? These systems and processes are likely unfamiliar to AAAs and training is important.

Training will be provided – vouchers for HCWs, MMIS for In Home Care Agencies and some other services, and for some FCAP services, payment via a Fiscal Intermediary will be developed.

Training

Do we want all AAAs to have access to all of the OPI-M and FCAP training since they will all be doing case management, correct?

Yes, training will be available for all AAA staff.

Is the training schedule available?

The OPI-M/FCAP training is a series of online modules and will be released gradually. Module 1 is self-paced and is available now in Workday. This training is intended for all APD/AAA staff to get familiar with these programs. Click here to access Module 1.

Will there be regular OPI training?

Yes. OPI training will continue to be offered twice a year. OPI training is only available to OPI staff that administer the program. Review the *Service Program Comparison Chart* in CM Tools under Other Links and Tools to learn about OPI. APD staff are encouraged to talk to their local AAA offices about OPI and other OAA programs available in their area.

Are there going to be trainings offered for staff to compete to get up to speed with the systems used such as ONE, access, EDMS, etc. I am assuming we already have some basic trainings for these systems. Have those been shared with other agencies or are there going to be OPI-M specific trainings developed?

We are working on tutorials for AVS, Oregon ACCESS, and navigation in the ONE system that will be focused on OPI-M/FCAP. These trainings are meant to coexist with trainings offered by Oregon Eligibility Partnership (OEP) and Medicaid Financial Eligibility training units.

It said the "eligibility" CM will be trained, but what will that look like? Some of us have been here less than a year and have no eligibility background. Will we be doing financial eligibility like an eligibility worker?

Module 2 is currently being developed for APD/AAA staff that will be determining service and financial eligibility for OPI-M/FCAP applicants. This training will cover

service and financial rules, any application review process, and how case managers will be gathering financial information.

Specific workload is going to be dependent on your office. Additional positions were allocated to offices and funding to help cover the additional workload. Some offices may be intending to have a dedicated case manager that will only review eligibility but other offices may have all case managers review for financial eligibility. We are developing a training to go over the financial eligible review process.

Will the case managers receive talking points or brochures, or something to reference when option counseling? Screeners will need to know more, and would they be referring callers over to the AAA or OPI office vs APD case manager?

Yes, training, brochures, and tools are under development. Depending on what area referrals are received, this will determine your process. Currently, there is a *Service Program Comparison Chart* in CM Tools under Other Links and Tools to help staff with talking points and information about services and support options.

Part of that the switch between who does it go to- does it go to APD or ADRC or the AAA? depends on the local area and the process developed by that area. The type of referral or service request will determine which process is followed.

Are the remaining modules of the OPI-M and FCAP trainings waiting for CMS approval before becoming accessible?

CMS is not approving training specifically. If a CMS policy decision would change what is trained, Central Office will not release the training until the CMS decision is made. The remaining modules are under development. Much of the information is dependent on CMS approval and decisions around internal processes have not been fully confirmed. The training unit is working hard to create trainings with the most accurate information and this means they will be gradually released.

Will OPI-M launch after training is complete for staff? Is there no way to be more specific like will the soft launch happen this month?

Central Office is working with local APD and AAA local offices to create a ready to launch checklist. The launch will occur when the conditions on the checklist have been met. Training is on the list. There will be a lot of communication in advance of the soft and the public launches. OPI-M and FCAP will soft launch about 60 days after CMS approval. The goal is for all staff to be trained by the full public launch, not by the soft launch.

Staffing/AAA Budget/Claiming

Will AAAs be able to claim ADRC I&R if they are talking about OPI-M and FCAP like they do with traditional Medicaid? Would there be any difference since these would be waivered services?

Yes – this would be ADRC I&R and Options Counseling billable. No -there is not difference.

If a person is already receiving OPI-M or FCAP but not Medicaid LTSS, can I&R and OC still be claimed?

No – this is Medicaid and the AAAs are getting paid through the 1115 to provide the services.

What will happen to the AAA allocation?

Allocations will change in that the allocation for traditional OPI will decrease (potentially to about 20% of current funding). AAAs will receive other funding for OPI-M staff. The costs of OPI-M/FCAP services will be paid by APD.

If there is no cap on enrollment, how will the agencies handle a potential lack of ability for the AAA to handle the workload? It is hard for us to find employees. If the AAA is not able to find enough staff to cover the service planning, what is the backup plan?

The AAAs are receiving new funding, in addition to the OPI funding. It is intended to provide sufficient funding to allow the AAAs to hire sufficient staff. In future biennium, there will be a workload model that provides ongoing funding for the AAAs. If a AAA cannot keep up with the workload, it will need to discuss the

situation with Central Office. Central Office will be working closely with the AAAs to help them be successful.

We have several new case managers hired, it will take at least a year to train them, the caseloads are high enough that both the intake and ongoing teams are barely hanging on. We wonder how feasible it is to manage this new workload.

Additional positions for APD offices as well as additional funding to the AAAs have already been allocated so staff are beginning to be hired to support the future additional workload. Each office will determine how to manage the workload: some offices may be intending to have a dedicated case manager that will only review eligibility while others will likely have all their case managers handle OPI-M and FCAP services case management.

Direct Care Workforce

What's happening on the workforce development front? Has there been any activity? Has the pool of workers increased? There is a lack of workers to provide care, and this will be a major challenge.

Central Office is aware that workforce is a major challenge across our entire system including homecare workers and in-home care agency caregivers. The Oregon Home Care Commission is working to expand capacity of HCWs.

Many OPI consumers will bring their existing providers with them when they convert to OPI-M. It is hoped that many of the OPI waitlisted consumers will have family or friends willing to provide the services.

How do we promote OPI-M and FCAP? I work in a small office and remote area of Oregon. Will there be any added services coming to this area that aren't already available?

Services will likely be limited to what is available in each area at first. Some new services may become more widely available by having access to Medicaid funding. As the programs evolves, service availability will be monitored and addressed as feasible. FCAP offers additional opportunities as well.

Miscellaneous

What is the percent of people who screen out of LTSS for financial reasons, in each APD District? Use to estimate potential case load for 1115 programs.

We have requested this data but do not have it yet.

Will OPI-M cases be subject to reviews by the HCBS audit team?

Central Office is still deciding on the process and protocols for reviews and program evaluation.