

Office of Developmental Disability Services (ODDS)
Provider FAQ

INTRODUCTION

This Frequently Asked Questions (FAQ) document is developed as questions are presented to the [Office of Developmental Disability Services](#) (ODDS) by the service delivery programs within Oregon. These being the Community Developmental Disability Programs, [Support Service Brokerages](#) or provider organizations. The FAQ document is being distributed to help clarify and facilitate the services provided by ODDS for adults with Intellectual and other Developmental Disabilities (I/DD) in Oregon. The answers provided in this document are current as of April 20, 2015 and are subject to change based on policy and rule changes.

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Expenditure Guidelines

Q. Is an individual who is receiving OHP+ but not OSIPM eligible for placement in a group/foster home? This individual is not receiving SSI (is applying), so he has no money to pay Room and Board, or spending money, but can we place him in foster care? Apparently with group/foster home under the K Plan, he is now eligible?

A. The individual must be either OSIPM or Title XIX OHP Plus eligible in order to access k-plan services. You are correct that there would be no R&B for this provider, but if the provider agrees to provide services without the R&B that is up to them.

Q. CIIS was paying for Agency Busy Bee to “help” the individual with chores. The individual is really and truly unable to do chores with assistance (extremely medically fragile) but does need her environment to be clean due to the fragility and susceptibility to illness. Are we able to still pay for this service to continue in an adult in home plan? It’s been paid through ADL/IADL funds.

A. Yes. Expenditure Guideline DD49 would pay a qualified provider for ADL/IADL service (PSW, In Home Agency) to provide assistance with the IADL of housekeeping. This would come out of the assessed hours. Light housekeeping should come out of IADL hours assessed as it is defined as an IADL.

Q. A plan has a significant amount of specialized supplies authorized, if those needs continue to exist, can those supplies be authorized in a renewed plan?

A. Yes. Supplies are in the Comp, CIIS, and Support Services Waivers effective 7/1/2014. The Waiver would be the funding source for those supplies. Supply payments cannot be reimbursed to a family member. The payments need to be directly to a vendor for the supplies.

Q. Please clarify whether there are time limits and funding limits related to job coaching. What if a 1:1 job coach is needed at all hours the person works?

A. Job coaching is limited to 40 hours per week. It is limited to 25 hours per week if combined with small group supported employment and employment path services. The need must be identified in the ISP. Annual goals should continue to focus on increasing the individual’s independence and the job coach’s fading.

Q. What if a family uses K Plan Relief care and only uses 15 hours out of the 24 hour period? Does the PSW get paid the rate of \$175.00?

A. Yes. This is a flat rate, regardless of how many hours are used.

Q. Can a person, adult or child, in foster care or group home access assistive devices and technology or other services through the K plan?

A. Yes. A Supplemental Support Documentation form must be completed. Basically, there needs to be further/deeper exploration of the situation in the home and see how best or what would be most cost effective options to support the child to be in the home.

The assistive device or technology must fall under an identified need specific to the disability and expenditure guidelines for Comp services. At this time, CDDP must submit an invoice to ODDS for reimbursement out of Special Projects (DD57).

Q. Are we able to purchase weighted blankets and vests, etc. at this time?

A. Yes. It must be purchased through Special Projects (DD57) for individuals in Residential Facilities (DD50) and Foster Care (DD58). For individuals in an in-home program (DD49, 149, and 151) normal ISP process should be followed. The Supplemental Support Documentation must be completed in both cases.

Q. Can we start including environmental modification in K Plan services?

A. Yes. Authorization would need to adhere to the Expenditure Guidelines, and require the use of the Supplemental Support Documentation.

Q. When an individual requests an item or service for which another individual or program is liable, does it need to be provided or a Funding Request submitted when it is above the financial threshold?

A: No. ODDS does not pay for items or service when there is a third party liable for the cost. Individual Support Plans should include the item/service needed for support and identify the appropriate party (landlord, health insurance, etc.) to provide it. Those requests requiring funding review for authorization or approval should not be submitted to ODDS until all other resources have been exhausted. ODDS will not assume liability for items or services which are the liability of a private party. However, ODDS may authorize expenditures for medically necessary items or services when the health plan benefits have been exhausted. In that case,

the documentation of insurance denial and a decision upholding the appeal of the denial must be submitted with the Funding Request.

Q. If an individual requires multiple items to serve one identified ISP need or goal, is it a \$500 cap for line-items or aggregate cap? For example, if an individual requires a communication device and identifies a tablet computer as the assistive technology that will be meet their needs, and also requires specific apps as well as a safety case, if the total of all of these items exceeds \$500, does ODDS need to approve this? Or only if a single one of those items exceeds \$500 does ODDS need to approve?

A. If the total cost of purchases identified to meet that individual ISP need or goal exceeds \$500.00, ODDS must approve this purchase. A Funding Review request must be forwarded to ODDS.

Q. For brokerage customers who need to access relief care in an Adult Foster Care Home, how is room and board paid for?

A. During the service of Relief Care, Room and Board payments are not made. When brokerage consumer will not return to the brokerage, they are entering into AFH. As soon as CDDP enrolls the individual into AFH the individual will pay for R&B.

Q. Can washable training pants be purchased with k-plan funds for a child that is currently receiving incontinence briefs paid for by the medical plan?

A. Assuming all the necessary ground work has been completed.... If the medical plan has denied the request for this assistive device it can be included in an ISP.

Q: Can K plan or waiver funds be used to offset the purchase of a service animal should the outcome decrease attendant care needs similar to that of an assistive device/technology?

A: No, Service Animals do not meet the definition of any of the services offered under the K plan or waiver.

Q. Will K-plan pay for a sex offender assessment for an individual who has not been adjudicated?

A. Yes, but not ongoing treatment. Payment for the assessment needs to be invoiced after receipt of the evaluation. For a CDDP, the invoice would go to the CAU invoice email box for processing. For a brokerage, it would be paid as any other invoice would. The need for the assessment must be supported in the customer's record. If a Goal Survey is in use, it can be the place to document the need, otherwise, for the time being, a progress note will suffice. When the new One ISP comes into use, the need can be documented through the risk tracking record on it.

Q. Can a stepparent who lives in the home be paid to provide in-home supports for a minor child?

A. No, a stepparent is considered a parent of a minor child, and therefore cannot be considered as a provider and be paid with in-home support funds. Below are the supporting OARs:

411-308-0130 Standards for Providers Paid with In-Home Support Funds

(2) Each independent provider who is not a personal support worker who is paid as a contractor or a self-employed person must:

(e) Not be a parent, adoptive parent, stepparent, foster parent, or other person legally responsible for the child receiving supports;

411-308-0020 Definitions

(54) "Parent" means the biological parent, adoptive parent, stepparent, or legal guardian of a child.

(23) "Employer" means, for the purposes of obtaining in-home support for children through an independent provider as described in these rules, the parent or a person selected by the parent to act on the behalf of the parent to provide the employer responsibilities described in OAR 411-308-0135.

(61) "Provider" means a person, organization, or business selected by a parent or guardian and paid with in-home support funds to provide support to a child according to the ISP or Annual Plan for the child.

Q. Can k-plan funds be used to do a home modification for a Jacuzzi tub when it is prescribed by a doctor to reduce the need for more invasive medical procedures and improve mobility?

A. Generally the answer is no, this is almost never the least cost effective manner in meeting a need. If this was presented to the Funding Review Committee there would be an expectation that there was evidence that this treatment had been demonstrated effective with the specific

individual (example: accessed this treatment at a PT office and reduced need for more invasive treatment) and that there is no other more cost effective manner to meet the need (example: portable tub or device that retrofits to the existing tub).

Q. Can Faro wraps for lymphedema be purchased with k-plan funding?

A. Yes, this type of assistive device can be purchased if it is prescribed by a physician and has been denied by the health plan. Also remember to explore alternative resources that may be available.

Q. Is Home Delivered Meals a service available to children?

A. No, it is not, as meals are expected to be provided by their parents/legal representatives. Thus you will not find this service referenced in any of the OARs where other K-plan services are listed (i.e., 411-308-0120).

Q. Do we have any direction on how one defines a facility when it comes to facility vs. community attendant care supports performed by an agency? In particular, what if a provider does a lot of classroom-based small group skills trainings that occur in a building that they own? Some say that everything they do should be classified as community supports because they are not licensed as a facility-based program.

A. Under Oregon Administrative Rules (see OAR 411-345), and the expenditure guidelines, *"Facility-Based" means the service occurs at a fixed site owned, operated, or controlled by a service provider where an individual has few or no opportunities to interact with people who do not have a disability except for paid staff.* It isn't related to the presence (or absence) of a license.

Q. Why did ICs performing skills training not get to keep their prior rate as part of the held-harmless agreement when skills training is a PSW task in the expenditure guidelines?

A. Skills training prior to the availability of k-plan were time limited and outcome based and the providers of such were not a PSW by definition. When skills training was removed from the waiver and became available under k-plan as a non-time limited service the providers now meet the definition to be considered a PSW.

Q. A child resides in a Child Welfare Funded foster care home and child welfare is paying the service payment to the foster care provider. Per APD AR-14-038, the child may also be eligible for in-home supports through the k-plan. How does the foster care provider either get paid for attendant care or hire providers for attendant care?

A. When a child resides in a CW-funded foster care (FC) home, the service payment for the foster care is paid by Child welfare directly to the foster parent. Any additional DD-related supports brought into the CW-funded FC home would be paid by ODDS directly to the providers (such as a PSW or in-home provider agency), once provider qualifications are met according to OARs 411-308-0130 and OAR 411-375-0020.

In these situations either a PSW or an in-home agency may be hired to provide additional attendant care through the k-plan to the child. The foster parent cannot be the foster provider and the PSW/in-home agency provider for k-plan attendant care. If a PSW is the chosen provider, the FC parent would be the Employer and assumes the responsibilities of an Employer per standards under OARs 411-308-0135.

Q. A current PSW/DE of a customer (her sister) does not drive. The customer would like the sister to provide ADL/IADL supports during transportation. They are asking for mileage reimbursement for a different person (not providing ADL/IADL supports) who does agree to drive them. The driver obviously would need to become qualified but wouldn't be providing any other supports

A. Mileage cannot be claimed by a person who is not also being paid another service simultaneously, such as attendant care. If a PSW is providing transportation and being reimbursed for mileage, they must be paid a wage at the same time.

Q. We have a client who needs a stroller due to his disability and a decline in his mobility due to his developmental disability. We have the recommendation letter and denial from OHP. The child's private insurance will pay for 80%. Can the K-plan pay for the left over 20% that the parent would normally pick up?

A. Assuming all the appropriate criteria for purchase in the expenditure guidelines are met, the K plan is a resource for the remainder of the cost of the device. The CDDP would be required to maintain documentation of the total cost of the device and the amount paid by the third party payer (the private insurance). The remainder of the cost can be built into a POC authorization. The ISP should clearly identify the contribution of the third party payer and cost covered by the K plan.

Q. My question is regarding attendant care being provided in a group setting. My understanding from reading the Expenditure Guideline version 2.0 is that only provider organizations can provide group attendant care, and Independent Contractors can no longer provide this support. Is this correct?

A. Both types of providers can do attendant care with more than one individual at a time. The difference between the two is how rates are handled. The IC prorates (as before), the agency must use the ReBAR group rate per individual.

Q. If an exception for on-going supports (attendant care hours above the assessed support hours, behavioral consultation, relief care, employment or other service that is available as an on-going monthly support) is approved one year, do we need to continue to request the exception each plan year if the support is still needed?

A. Yes. ODDS is looking at trends and possible options and services that can be approved locally for exceptions by program managers and brokerage directors. This will be communicated clearly once these services and criteria are established. Until further notice, exceptions and funding reviews must be requested each plan year for each individual as determined necessary and appropriate by service coordinators or personal agents.

Case Management Activities

Q. Waivered Case Management. If an individual is in Waivered Case Management, it is my understanding that they need to receive a Waivered Service every month. That service could be their residential or employment services, and is not necessarily their SC contacting them every month. So in other words, if someone is receiving WCM, the CDDP does not need to contact them every month, or provide a service every month, but the individual does need to receive a waivered service every month?

A. So that a person remains enrolled in the waiver, s/he must receive a waivered service each month. Those services can be: Individual Supported Employment; Small group supported employment; Discovery/Career exploration; Employment path services; family training; Waivered case management and a few others. As long as the person is receiving a waivered service each month, their waiver status remains intact. When there is irregularity in receiving a waivered service, it is beneficial for the Services Coordinator to check in with the individual (monitoring their progress, checking in on services delivered, etc.) to assure that the waivered service is delivered. In your note above you list residential as a waiver service, and it is not. It is considered a K service, because the essential services being provided are the ADL and IADL services paid for through the K.

Q. Do Waivered Case Managements require a monthly reciprocal contact?

A. No, individuals enrolled in the waiver must receive a waiver service each month. This could be an employment service or a family training service or a waiver case management encounter. Waiver case management includes any qualifying case management encounter (billable contact). This is separate but related to the monitoring Case Management Contact which needs to occur with any individual with an ISP at least quarterly.

Q. What is the update on the crisis mandated caseload data? Regions and SACU rely on this data.

A. Data was last entered October 2013. ODDS and SACU completed this entry. All data is now caught up.

Q. If an adult client has a Employer of Record (EOR) document signed with TNT does the SC/PA need to do a Designated Rep document for the file as well?

A. The EOR is not necessarily the Designated Rep, so yes, if an individual has both, each role has to be supported by the appropriate documentation.

Q. For a Case Management Contact, is the only thing that qualifies monitoring health, safety, and ISP implementation? Nothing else counts as a Case Management Contact?

A. Case Management Contact is one specific case management activity (billable/qualifying encounter) for the purpose of monitoring identified risks, ISP implementation, and individual satisfaction with supports. In order to meet the requirements of a Case Management Contact all of those areas must be addressed during the contact. The Case Management Contact could be done in conjunction with other case management activities. It must be reciprocal with the individual or designated rep. There are many other types of activities that qualify as case management services.

For example, a Personal Agent contacts an individual by phone to give information on resources he can access for employment supports, at that time the PA also gathers the necessary information about health and safety, ISP implementation, and his satisfaction with his current supports. Document both activities in progress notes. The Case Management Contact requirement is met.

Q. Can individuals receive non-waiver case management with no other k-plan or waiver services from a Support Services Brokerage?

A. Yes, aside from DD eligibility, there are no special requirements for an individual to receive case management services from a Support Services Brokerage. Individuals can choose to receive case management as their only support from a Support Services Brokerage.

Q. If an individual's Level of Care expires or the individual is exited from all k-plan and waiver services what are the timelines for being able to access services again?

A. If the individual meets the financial and DD eligibility requirements for the service, the individual is able to begin receiving services (waiver or k-plan) the day that the new Level of Care is completed – that includes signatures of the Service Coordinator and individual or their representative provided and that the other required components for the service are also in place (assessment and approved ISP). Please see the Level of Care Technical Guide for further instructions <http://www.dhs.state.or.us/spd/tools/dd/cm/level-care-assess-tech-guide.pdf>

Q. For someone who enters the brokerages already enrolled to a waiver, after the enrollment date, the brokerage is required to either provide monthly waiver case management, ensure receipt of a monthly waiver service (i.e. employment supports), OR if the customer is not interested in any waiver services upon enrollment, then the PA would issue a NOPA to the customer (terminating eligibility for waiver services), and submit a 4111 to the CDDP to reflect this change and to dis-enroll them from the Waiver?

A. Yes.

Q: What are the expectations for continuing to provide case management services to adults with I/DD who are in jail, whether they are sentenced or not? And what are the expectations for an 18 year old with I/DD who is also served by OYA. In this case the young person is out of county. If termination of services are required, what OAR do I cite?

A: The CDDP rule is silent on discontinuing case management to adults in service who are also in jail, whether sentenced or not. It is the same for individuals also served by OYA. In both cases, DD case management can still be a very valid and important service to provide, as long as the I/DD diagnosis remains. When people are involved in an institutional setting, the case management services are still available but the Department does not claim Medicaid match funds for the service. Remember that in order to bill, one needs to be sure that the case management being delivered meets the requirements of an allowable encounter (including but not limited to: monitoring; assessment and reassessment of needs; coordination of services,

etc.).

I would advise you to have a conversation with each individual and ask if s/he wants continued case management services. If the person decides that s/he no longer wants case management services, then a notice citing the complaint and notice rule could be used:

411- 318-0020 Notification of Planned Action

(Temporary Effective 07/01/2014 to 12/28/2014) (1) An individual and the representative of the individual must receive a written Notification of Planned Action in the event that a developmental disability service is involuntarily denied, reduced, suspended, or terminated or voluntarily reduced, suspended, or terminated.

In the Action and Reason for Action portion of the Notice, be sure to detail that you offered continued case management, and that the person voluntarily declined that service. If there is additional relevant information to that decision, you would capture that in this section as well. Regarding the young person in OYA services, since s/he is being served in another county, and should s/he desire continued case management services, you could pursue whether the county in which the person lives would be willing to do courtesy case management until the home county would need to become involved for transition back home.

Q: For someone in an in-home program, can we authorize supports delivered outside of the country?

A: No payment can be made for services delivered outside the country according to 410-120-1180(6) The Division makes no reimbursement for services provided to a Client outside the territorial limits of the United States. For purposes of this provision the “United States” includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

Q: For someone in an in-home program, can we authorize supports delivered outside of Oregon?

A: Services can be delivered across state lines when that is the nearest place the service is available, consistent with the concept that the individual’s community is the places commonly used by people in the same area to obtain ordinary goods and services. For example, in one part of southern Oregon, the nearest town in the area is across the border in Alta, California. If Alta is where community involvement happens for people who live in that part of Oregon, then our customers should be able to receive supports there.

When an individual in an in-home program wants to travel further distances or for longer, there are a different set of circumstances to consider. Nothing in our rules or other regulation strictly prohibits the delivery of certain supports in other states, but there are planning considerations.

A case manager and individual should have a plan for the possibility that the paid provider will become unavailable in the other state. Within Oregon, through the CDDPs, we can assure access to an appropriate short term placement such as in a foster care home. Oregon does not have similar resources elsewhere. The individual must be clearly informed of the limits of the case manager's ability to offer assistance. Best practice would be to assess risks (can the individual get home without the paid support?, take necessary medication?, etc.) and develop plans to mitigate those risks to assure health and safety needs can be met while the individual is traveling out of state.

Q: Do you have any of the PSW enrollment documents translated into any other languages other than English?

A: ODDS is working on translating these documents. ODDS will also be working on ensuring all documents that are created or amended by ODDS will be available in Spanish, Vietnamese and Russian.

Q: The Children's In-Home OAR says that we can pay up to \$500 for a family to attend a training (training fee only - no lodging or mileage). The Expenditure Guidelines limit \$240 per event. Which is correct?

A: The current temporary OARs 411-308 does allow a max of \$500 per family for an individual event; that dollar cap amount, however, has been proposed to be taken out for the permanent OAR effective December 2014. Until the proposed OARs become permanent, \$500 max is allowed in the temporary OAR through 12/28/14. As of 1/1/15, follow the Expenditure Guidelines version 2.

Q: Someone on my caseload was in jail for 3 weeks. His plan included Waiver Case Management (WCM), how come eXPRS is denying the claim for the WCM provided while he was in jail?

A: When an individual is in an institutional setting (jail, hospital, nursing facility) they are not eligible to receive any type of waiver or k-plan funded services; WCM is a waived service. This does not mean that you cannot provide case management services; it is considered non-waived case management services rather than WCM during this time. The service you are providing is the same, the funding mechanism is different.

Q. If the plan is staffed by a provider agency does the customer need to have current medication orders for staff to give them medications? Any direction you can point me in for this case is greatly appreciated.

A. The agency will need to follow the rules that they are qualified under. DD qualified providers have rules in the Certification and Endorsement OAR. If it is another Medicaid qualified agency they may have different rules they are bound to.

Q. Is community transportation a service available for children under the age of 18 written in an in home plan. Or is this considered parental responsibility?

A. In most situations transportation is generally considered parental responsibility. The two identified situations where transportation for children can be authorized without ODDS approval via the Funding Review Committee process are when the child is receiving relief care, therefore the parent is temporarily not providing their typical responsibilities and when the child has a Behavior Support Plan where the interventions prescribed support the need for transportation to implement the plan effectively.

Q. We have an individual that will need extra hours during January as he will have less natural supports that month. He will not be using all his ANA hours in December. Will it be okay to simply move 22 hours to January to meet the needs of the individual or does it need to be formally documented in a K Plan?

A. Hours cannot be moved from one month to the next. The loss of a natural support provider should not impact the number of assessed hours an individual requires. For example, if an individual is assessed as requiring 200 hours a month (based on the ANA), and a family member identifies that they are going to provide 50 hours of natural supports in the month, then the plan can still be written to identify that the person requires 200 hours of support but 50 of the hours will go unclaimed by the natural support provider. This way, in the event of a need to have an hourly relief provider or alternate provide “sub” in for the provider who is providing natural supports, the ISP does not need to be amended. This is simply a change of providers.

If this provider is providing support on top of the assessed ANA hours, this is different and will require additional conversation to identify what types of supports are being provided and why this need is not captured in the Assessment.

Q. My question is for a child who is at a residential school where he lives out of the home 4 nights per week throughout the regular school year, 3 nights per week at home. He has summers at home as well. Should we be writing the ISP using the full assessed CNA hours despite the fact that he is not living at home for a significant part of time during school months? We would of course include a caveat that the full assessed hours cannot be used since he is in school. Or – would you prefer us to prorate the assessed hours to our best guess, like write the ISP only for 50% of the assessed hours since he is living in the home only 50% of the time.

A. You should be writing the ISP to identify all the resources that will be brought to bear in meeting all of the identified support needs. The person centered planning process will help the individual and case manager to identify these resources, to identify the settings in which they will be provided, and to identify in what amounts they are needed at each setting. To the extent that the school is meeting those needs, they should be identified as doing so. Any natural supports should be identified. If there are remaining, unmet needs, as many hours as are necessary to meet them may come from those determined to be necessary through the CNA. As always, the CDDP is expected to closely monitor this type of situation to be able to adjust the ISP as necessary -- e.g., when he's not at home due to illness. The service agreement (or any other name) would need to clearly identify the supports provided in the home.

Q. If an individual plans to use a set number of their ANA hours for community inclusion activities under Group Attendant Care and they become sick or are not able go with the group, may those hours be used at home for 1:1 attendant care?

A. Yes- the individual may access all of the attendant care hours determined necessary by the ANA. The plan should be written in such a way that reflects the outcome of the person centered planning process. An individual may choose to strictly allocate available hours for one provider and setting or another, or the individual may allocate up to the amount of hours that they might conceivably use in various settings from various providers up to the maximum number of available hours determined to be necessary. For instance, if an individual has 100 total plan hours and typically uses those hours as ADL/IADL support at home and uses 25 hours for group attendant care, the plan could be written to indicate that the individual has “up to 100 hours of ADL/IADL support at home,” and “up to 25 hours of group attendant care.” Thus, they can be used at home if they are not used for DSA. Please note, this would not be the same for employment, as employment is not based on ANA hours.

New **Q.** Can an ISP be authorized if case management is the only service being authorized at the time that the plan is signed?

A. Development and authorization of an annual plan as defined in Oregon Administrative Rules meets necessary requirements when the only service provided is case management. However, it is reasonable for the SC/PA to authorize an ISP (using the statewide ISP form) that initially includes only waived case management while the SC/PA engages in activities related to providing information and referral to resources, such as assisting the family to identify attendant care providers, and ensure that the providers meet the minimum qualifications. The ISP should indicate how the individual's needs are being met through other sources or through natural supports while the SC/PA is assisting in identifying qualified providers of attendant care, researching specific assistive devices, technology or other identified needs.

To authorize an ISP providing only case management services, the SC/PA must assure that the;

- individual is Medicaid eligible
- Level of Care Assessment has been completed
- Needs assessment has been completed

The ISP may identify non-paid supports pending those same supports meeting minimum qualifications and becoming enrolled as SPD Medicaid providers. An ISP that authorizes case management as the only service must also describe how the identified assessed needs are being met through other resources.

It is not appropriate to authorize an ISP with case management only when the individual does not require any case management services and is accessing waiver supports solely for the purposes of obtaining other Medicaid benefits (OHP).

Day Support Activities

Q. We are concerned that an individual in Supported Living will not have enough daily support hours in the home if a portion is used for Day Support Activities. It was communicated at the August 2014 Program Manager's meeting that the use of Day Support Activity hours and the related reduction of the available ANA hours might not apply to Supported Living. It may only apply to Support Services and DD 49. We transferred the ANA's to the ANA-B so the individual would have all possible resources to use toward support in the home as well as DSA if desired. It will be a relief if the ANA hours do not have to be used for DSA.

A. At this time, if the individual has NOT had the ANA-B completed, AND has been receiving Day Habilitation/ATE/(as of July, now DSA) prior to July, those hours may be added to the individuals plan on top of the ANA-A assessed hours per the transmittal PT-14-019. Once the ANA-B is completed, the DSA hours are included in the ANA hours. If an individual is in SL and assessed at 30 hours a month of support and through the person centered planning process, chooses to receive 10 hours a month of DSA, this will be deducted from the 30 hours for supported living.

New **Q.** Today at an annual ISP meeting a county services coordinator refused to re-authorize day support hours because the "My Declaration Not to Pursue Employment" form ends with the following sentence: "I also understand that by making this choice, I will not be able to receive any waiver-funded employment services, unless I change my mind and decide to explore, pursue, obtain or maintain community employment."

My understanding is that Day Support is not an employment service and that choosing not to work does not bar an individual from receiving Day Support services. I believe the services

coordinator is misguided or confused because the description of Day Support is contained in the Employment Services Rule.

A. You are right in your understanding that DSA is not an employment service. A person, who chooses not to explore, pursue, obtain, maintain or advance in integrated employment, may request DSA. That same person is not eligible to receive ODDS funded employment services which are Employment Path Facility, Employment Path Community, Discovery, Small Group Employment, Job Coaching or Job Development. That individual can choose to begin down a path to employment at any time and begin to access Employment Services.

Notification of Planned Action (NOPA)

Q. If an individual qualifies for 100 hours on the ANA, but feels that their needs can be met in 80 hours per month, we would issue a NOPA? (Even if the plan states that they are eligible for 100 but are currently choosing to use only 80?)

A. A NOPA is only required if the plan is changed based on the request of the individual. We recommend that the plan continue to authorize 100 hours, but the individual has the option of using fewer hours if desired or if they are receiving natural supports rather than paid supports.

Q. Does a reduction apply to situations where individuals use natural supports to meet their needs? (I.e. they qualify for hours on the ANA but the plan is written as a \$0 goal because the individual chooses to receive natural supports). I'm referring to situations where the needs have always been met by natural supports (there are no services that are being taken away).

A. Reduction only applies if plans are being reduced, or the individual is eligible for less hours. Plans can also be written for assessed number of hours and 0 hours claimed if the provider chooses to provide natural unpaid supports. Plans can always be written without the requirement that the provider submits claims. If plans are written for 0 hours and something happens to the provider who is providing natural supports, then the plan will need to be amended if hours are to be added to the plan for a relief care provider to provide supports.

Q. Does termination refer only to situations where the individual is requesting to terminate brokerage services entirely?

A. No. It applies to anytime an on-going service is being ended or taken out of a plan (would not apply for one-time purchases once the purchase was made and this one-time item is not added to the next annual plan). If the individual is receiving employment supports and then chooses to no longer have that service, the employment service is being voluntarily terminated and a NOPA is required.

Q. Do we have to issue a NOPA every time an individual voluntarily chooses to stop receiving services from a particular provider?

A. Not if they are choosing to stop services with the provider – just the service itself. In this situation, the individual is still eligible for the service.

Q. When would it be appropriate to send a NOPA re: suspension. Would we send this kind of NOPA if a person is hospitalized, incarcerated, etc.? Often we don't find out until after the fact.

A. Suspensions would be appropriate for hospitalizations and incarcerations although, ODDS recognizes that this has not been practiced consistently in the past. Additional guidance will be coming out regarding these specific situations and required notification and administrative functions.

Q. Would we send a suspension NOPA due to No Contact at plan renewal? Or would we just send a Termination NOPA, stating that their services will be terminated on XX date if they do not participate in planning for their ISP? (In the past we have sent a "30 day notice" via NOPA.)

A. These would all be Terminations. A NOPA is required at least 10 days prior to the action taking place. Planning should occur well before the end date of the plan and if there has been no contact or response from the individual and/or their representative 10 days prior the end of the plan, then a NOPA should be sent out.

Q. At plan renewal time, the ANA results in a reduction in hours. Currently, if there is a reduction in hours, we write the NEW plan at the NEW hours (per the ANA). Based on the timelines listed above, is it saying we MUST send the NOPA on or before the 18th of the last month of the (current) plan? If the NOPA is sent on or after the 19th of the month, does that mean that the new ISP (which starts on the 1st) must include the old (higher) hours for the first month of the new plan?

A. Yes – also remember that if an individual asks for a hearing and continuing services during their hearing, they are eligible to continue receiving the previous plan level of service/hours of service, but they may be required to pay these benefits back if they lose the hearing. It's best practice to issue a NOPA as soon as it's identified that a reduction of support hours will occur. In most cases, the ANA and ISP will have been completed and reviewed prior to the 18th of the month. A NOPA may also be sent on the 19th of the month and end services at the end of that

same month so long as you are giving a minimum of 10 days' notice prior to ending services. Refer to OAR 411-318-0020 for more information regarding timelines.

Q. Loss of Medicaid. If we find out about the loss of Medicaid and send a NOPA on or after the 19th of the month, then we can continue paying for all services in the plan through the end of the next calendar month? Is there still an expectation that we send NOPAs within 10 days of verification of loss of Medicaid?

A. In these instances, you would send a 10 day notice rather than ending services at the end of the next calendar month OAR 411-318-0020(2)(b)(iii) allows for this 10 day notice. NOPAs should be sent ASAP after it's identified that the individual lost Medicaid benefits.

Q. The instructions say that continuation of benefits can be requested either verbally or in writing, but it also says that you should fill out the Hearing Request Form and indicate that you are requesting a continuation of services. Does this mean that they do not need to fill out the form, they can just ask for continuation of services verbally?

A. If the individual asks for continuation of services the conversation should be confirmed through writing with the individual/representative. Things can also be changed. If the individual/representative asks for continuing benefits and then decides to stop them, this is allowable. If they say 'no' to continuing benefits and then change their mind prior to the 90th day following the issuance of the NOPA, and the service is still available, they may be able to begin to receive the support again.

Q. I have an individual who has requested that they receive their in-home supports through a brokerage. The brokerage they have chosen does not have current capacity to serve this individual right now. Does the CDDP need to close them out of their current in-home plan since they have said that they want brokerage as their case management entity?

A. No. The individual should not have a lapse of service due to a choice to change case management entities from a CDDP to a brokerage. Continue to provide the in-home supports to the individual until the transfer occurs. It is important to ensure that there is no lapse in services during the transition, so please coordinate very closely with the brokerage that they are transitioning into. Additionally, the brokerage may accept the DD49 in-home plan for up to 90 days in order to maintain the continuity of services.

The individual can choose to end their in-home supports at any time and remain open as case management only, however this is not required if the individual wants to continue their in home services until there is capacity at the brokerage.

Q. Does ODDS need a copy of NOPAs that are sent to individuals?

A. ODDS does not need a copy of all NOPAs that are sent to individuals. ODDS will request copies of NOPAs when needed for Quality Assurance, Technical Assistance, hearing requests, and when a complaint is filed.

Home Modification

Q. We are finding that some contractors are requiring a percentage of payment for materials prior to completion of the work. The Expenditure guidelines read "Payment to the contractor is to be withheld until the work meets specifications. Support funds may not be used as a deposit." Is there a variance or other avenue to address this issue?

A. Language in the K-plan and Administrative Rules regarding prepayments, partial payments or deposits for Environmental Modifications prohibits such funding/payment. No variance would be allowed. Our guidance in the past has been to make clear to the contractors and family's prior to the start of work (or even during the bid process with all contractors) no prepayment, deposits or partial payments are allowed. A contractor will have to make the decision whether it can carry the costs until the completion of the job. If the contractor with the least costly bid cannot agree to this the family may have to work with the next in line contractor/bidder or may have to reopen the bids.

Q. For an individual window unit air conditioner will I need to have a contractor install the unit?

A. Yes. Because of safety and stability concerns with the window framing and installation as well electrical considerations a contractor must complete the work. After a scope of work has identified the dimensions of a window, safety concerns and applicable BTU dimensions for the room size the contractors can bid on the work. The bids should include the cost and purchase (by contractor) of the window AC unit. If in the course of submitting a bid a contractor or multiple contractors have identified a specific safety issue that needs to be resolved, the scope of work must be revised for all bidders. The least costly estimate (price) should be obtained unless there is a documented reason to purchase an alternative.

Q. What other considerations should a service coordinator be looking at for air condition window units?

A. It is critical to review for egress or the ability to exit in an emergency. Window unit air conditioners cannot be installed where it blocks the only window exit to a room. In such cases it may be necessary to look at free standing (portable) air conditioner units.

Another consideration is the possible costs to individuals or homeowners. If there needs to be some framing work to a window for the installation or some electrical outlet work in the room this cost could be paid for as part of the environmental modification. If however the home needs an electrical upgrade to support the use of the window air condition unit this cost must be covered by the individual/homeowner.

Q. If the individual/family decides a free standing (portable unit) AC unit will work do I need to go through a contractor?

A. No. Because it would not require a contractor to install and is portable it would not in fact be considered an environmental modification but rather an Assistive Device. Please review the expenditure guideline requirements for Assistive Devices.

ANA

Q. If an individual is authorized to receive 24 hours (or more with 2:1) per day the amount of hours shown in the ANA do not cover the total hours in months with 31 days but have more hours than are needed in months with 28 or 30 days.

A. At this time the CDDP can authorize above the hours if it adheres to the intent of the ISP. The intent of the ISP is for the individual to have 24 hours of care per day (or more with 2:1). Likewise, it would be expected that in months of 30 days or 28 days the providers would still claim only up to the total amount of hours needed per day which would result in less than the total amount of ANA allocated hours being used.

Q. For consumers who already have the ANA (original version) implemented into their plan, when is an ANA version B required?

A. ANA version B's need to be completed at renewal time, when there is a change in need, or if the consumer requests an increase to their Attendant care services. ANA version B is the only ANA version that will be accepted on or after 7/1/14. All individuals should have an ANA version B prior to 6/30/2015

Q. Individual does their own meal prep and can physically cut up food and eat independently. They lack the satiety reflex that tells them when they're full so they need support around portion control and overeating. Would this get captured under Eating/Drinking, or General Health Management?

A. Generally portion control and other diet management supports are considered under General Health. If the situation rises to the level where the person, if unsupervised while eating, consumes to the point of immediate illness (to the point of throwing up) and therefore requires active monitoring and intervention throughout ALL meals, then it might be rated under eating. If it is rated under eating, this same support should not also be considered when determining ratings on the Medical tab.

Q. Is a service coordinator or personal agent required to visit the home or residence of an individual prior to authorizing in-home supports?

A. The individual chooses the place of their assessment and ISP meeting and there is not a requirement that the PA/SC visit the home prior to being able to authorize services. Best practice would be to gather information about the living environment through observation or reports from the individual or their support people but it is not a condition to receive services. There continues to be a requirement that the ANA and LOC assessment occur during a face-to-face visit, however that visit can occur at any place of the individual's choice.

Q. Can you please clarify/recap the required timelines if a customer requests an ANA – what are the timelines to do the ANA, and then once the ANA is completed, what are the timelines to implement the results into the ISP?]

A. When an individual requests a new FNA (of any type), the case manager must meet the requirement established in the K plan and complete it within 45 days of the request. A plan must be revised within 30 days when a change is indicated.

Q. If an individual in Supported Living has had an ANA version B completed, do the hours that an individual spends receiving service from a community or facility based attendant care provider need to be deducted from the ANA hours?

A. Yes, individuals receiving Supported Living services that have had an ANA version B should deduct the hours spent receiving community or facility based attendant care from their total available attendant care hours.

Q. Do I need to do an ANA/CNA for an individual that is not requesting k plan or waiver services? In other words, the individual is requesting case management only.

A. A Functional Needs Assessment is required when an individual requests a k-plan or waiver funded service and meets both financial and level of care eligibility.

Q. I have an individual who, per their ANA is eligible for 33hrs per month. They signed their plan 1/12/15, and need the 33hrs for the rest of this month, however I have been told we need to pro-rate those hours.

A. For someone who it seems has primarily IADL support needs (based on the low ANA hours) and not the kinds of ADL support needs where we would expect them to need to happen on a daily or other regular basis like for bathing or toileting supports that not prorating based on a partial month could make sense.

This would be a conversation topic for planning around what needs those 33 hours will be meeting for the remainder of the month and how those needs are going to be met in a way that is more spread out in the next month. It is foreseeable that in the first partial month of the plan some needs have gone unmet during the first part of the month where there may be catch up or a more time intensive support needed for that shortened duration in order to adequately meet the needs that were identified on the assessment. ODDS would expect to see documentation of this discussion within the plan or progress notes.

However, on the other side with individuals that have the kinds of ADL supports that need to happen during the time the activity is actually occurring need to be prorated since either the provider is there to provide the support or they aren't. There isn't an ability to recapture that bath that didn't happen or assisting with more eating to make up for the meals that occurred during the part of the month before services started.

Q. I have an individual who is asking about attending camp. Can I authorize it?

A. "Camp" is not a service that is available under the K plan or any of the waivers. Services we do have available are Attendant Care and Relief Care. Some DD provider agencies that are qualified to provide attendant care and relief care also operate camps. Kiwanis, ACAP, and Upward Bound are examples. When an individual enrolled in an in-home program qualifies to receive Attendant Care and/or 24 hour relief care, they can choose to receive the service from any qualified provider agency, if the agency will accept the rate we offer. If the agency does not accept the rate we offer as payment in full for the service, the Department cannot pay the difference. Nor is it appropriate to ask the individual/family to pay the difference or any additional amount for the camp. If the camp accepts the Medicaid rate for Attendant Care or Relief Care, that payment represents full payment for the service and as Medicaid recipients, individuals/families cannot be asked for additional funds.

K plan funds can be used to cover the cost of attendant or relief care that any agency provides, including those that operate camps. If there are costs that are in addition to the cost of attendant or relief care, the Department will not pay them. The Department will not pay for recreational activities. Fees for those activities must be covered by another source. Also, the Department's funds cannot be used for a deposit or down payment. Funds may only be dispersed after a service is provided.

PSW's

Q. Do we continue to pay a CIIS provider the rate of \$15.20 an hour when the individual turns 18 and transitions from the CIIS program to an adult in-home plan? I know that any new providers that did not get signed up with CIIS are at the \$13/hr rate.

A. According to Article 14.2 of the [2013-2015 Collective Bargaining Agreement](#), CIIS rates do not continue when a child who had been receiving CIIS services turns 18 and changes service categories to the CDDP adult in-home plan. There was clarification with the Home Care Commission that CIIS is a separate service category therefore the rate is separate from the standard PSW rate. CIIS providers that continue providing services when the individual is an adult must have the standard PSW pay rate.

Q. Can a PSW be paid for attendant care services provided to more than one child that may result in working over 40 hours per week?

A. At this time, yes, unless the PSW is providing care for someone enrolled in the CIIS program. This is subject to change in the near future. Keep in mind the quality of care and safety for the individual receiving the care.

Q. Do relief care hours count into the 40 hour attendant care hours totaled for the work week for one PSW?

A. There has NOT been a policy directive to limit PSW hours at this time, but if there was a limit, these hours WOULD count towards the limitation. However, the CIIS program OARs specify that PSW's cannot work more than 40 hours per week.

Q. Do we still need to include FI fees within the \$1200 max for a Family Support plan? If so, it doesn't leave much for families as there is now a \$170 set up fee and \$40 per month charge.

A. SE-150 Family Support (general fund): The annual cap for Family Support (SE-150) funds remains the same at \$1215 (due to 1.25% increase, APD-AR-13-013), excluding FI fees (SPD-AR-11-027). For those who have an existing plan, the cap may be exceeding that amount because of the PSW's current pay rate of \$13/hour, in order to keep the same level of services.

SE-151 In Home Support (general fund): There is still the annual cap of \$1012.50, including FI fees.

For now, please follow the above guidance. There will be a formal communication when policy is changed for consistency between the 2 programs.

Q. As of September 1, 2014, all new PSWs will be required to participate in an orientation. What is the timeline for the PSW to participate and attend an orientation once they receiving their Medicaid provider number?

A. The Oregon Administrative Rule 411-375 refers to the timelines identified within the Collective Bargaining Agreement. At this time, there are no timelines identified for this training to occur. ODDS expect timelines to be added to the next Collective Bargaining Unit.

Q. Can we use Day Care Providers for attendant care as a general business contracted provider? We have used these providers for Family Support, but we are wondering if this will work for K Plan In Home Plans?

A. The K plan is explicit. On page 5 under Service Package (the section begins on pg. 3), it says "ADL and IADL supports will be provided by enrolled homecare workers, personal support workers, in-home agencies or in a licensed, certified or endorsed community setting of the individual's choice". A Day Care Provider is not qualified to provide attendant care. No general business is qualified to provide attendant care. Only those agency provider types listed in the K plan (starting on pg. 31) are allowed to provide it.

Q. This is regarding the proposal to pay agency providers the hourly attendant care rate for ADL supports in a 1:1 setting. Is the proposal that this rate be paid for just ADL supports? Will we still use the ReBAR rate for 1:1 job coaching and 1:1 DSA supports?

A. The hourly, agency attendant care rate will only apply to 1:1, non-facility based ADL/IADL supports, whether they are delivered in the home or in the community. The rate change should not be implemented until an official transmittal is issued. ReBAR rates will continue to apply to all facility based and group community inclusion supports and to all employment services.

Q. Are we (CDDPs or Brokerages) supposed to be limiting PSW hours to 40 hours per week due to the Department of Labor (DOL) rule regulations that are going into effect on January 1, 2015 for one provider working with multiple customers with the total hours exceeding a 40 hour work week? Or, one provider working with only one customer exceeding a 40 hour work week?

A. As of November, 2014, there are no restrictions to the number of hours that a PSW can work each week, either for one individual or in combination with multiple individuals (except for PSWs who work for a child receiving CIIS services). ODDS is working on developing policies related to the DOL regulations that are going into effect in January 1, 2015 with enforcement to the rules being delayed until July 1, 2015. Please look for future communications and policy changes related to the number of hours a PSW will be allowed to work in a week (Sunday through Saturday). ODDS will have other means of communicating the DOL policy changes in the future.

Q. What alternatives exist when an individual is having difficulty hiring a PSW that has the skills needed to implement the supports effectively for an In Home Service Plan?

A. In Home Agencies can provide attendant care services and may have staff available that have the skills necessary to implement supports for an individual. Also, the [PSW registry](#) may be a resource. An individual can browse available PSWs as well as post a want-ad. The registry is expected to grow as time goes on to include increasing numbers of PSWs.

Q. I am both a behavioral consultant and a PSW-IC (Independent Contractor). Do I need a provider enrollment number for both roles? Or can I use my current PSW-IC Medicaid provider number when I work as a Behavioral Consultant?

A. Providers who work both as a PSW-IC and a Behavioral Consultant, do need to have 2 separate Medicaid provider numbers. One for the work that is done as a PSW-IC and second for the work that is done as a Behavioral Consultant. There are Provider Enrollment Agreements with different requirements for each type of work.

Q. Would it be possible to have the PSW use hours in home to work on things such as laundry, housekeeping and meal prep while the individual attends their transition program? We were hoping to get some clarity on if the individual needed to be present for the hours to be used, or if some tasks could be done in their absence they are not able to participate in these?

A. The relevant CFR (§ 441.500) says that the K plan is for “the provision of home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, or cueing (emphasis added).” We take that to mean that the individual should be present to receive the services. We do recognize, and would make accommodations for, circumstances in which the individual’s health and safety would be jeopardized by participating in certain IADL activities (i.e. a ventilator dependent individual wouldn’t be expected to go with on a grocery trip). We believe the requirement for the individual to be present fosters increased independence, deeper community integration, and further assurance of individual’s health and safety. Under no circumstances would provider convenience be a reason for the absence of an individual during the delivery of an IADL support.

Q. Can you explain why a parent/step-parent (which I am) cannot be paid providers to their children?

A. Personal care or attendant care services authorized under Medicaid programs generally are not allowed to be provided by a family member, who is a legally responsible relative -- per Code of Federal Regulations Title 42, Chapter 4, part 440.167 (42 CFR 440.167). Legally responsible relatives include spouses or parents of a minor child. Oregon’s CIIS Home and Community

Based Waivers and the Community First Choice Option (the funding sources for CIIS services) do not allow for parents or step-parents to be reimbursed as providers.

Q. Who can be a Personal Support Worker (PSW)?

A. A personal support worker qualifications as summarized from (OAR) 411-375-0030:

- (a) Be at least 18 years of age;
- (b) Have approval to work based on a background check completed by the Department
- (c) Not have been convicted of any of the disqualifying crimes
- (d) Be legally eligible to work in the United States;
- (e) Demonstrate by background, education, references, skills, and abilities that the personal support worker is capable of safely and adequately performing the tasks specified in an ISP, with such demonstration confirmed in writing by an individual or the representative of the individual
- (f) Maintain confidentiality and safeguard individual information.
- (g) Not be on the list of excluded or debarred providers maintained by the Office of the Inspector General
- (h) Complete and submit a Provider Enrollment Agreement to the Department and possess a current provider number issued by the Department
- (i) Have a verified tax identification number or Social Security number that matches the legal name of the personal support worker
- (j) If providing home care services requiring professional licensure, possess a current and unencumbered license.

For more detailed information about the PSW qualifications please see OAR 411-375-0030 and Conflict of Interest Policy Transmittal APD-PT-15-009

<http://www.dhs.state.or.us/policy/spd/transmit/pt/2015/pt15009.pdf>

In addition to the requirements that are needed to qualify to become a PSW, the person-centered-planning process, along with the provider selection process ,should include discussion and decisions about the qualities, skills, and other preferences that the individual receiving services desires in a potential employed or contracted provider including PSWs.

Supported Living

Q. An individual who is enrolled in Supported Living has temporarily moved into a DD foster home. Is there a mechanism for the Supported Living provider to bill for some services during the time the individual is in Foster care, ie for admin to keep the program running? Because of our county's small size there are only 3 individuals enrolled in the program. Losing all revenue associated with one individual has a serious impact on the program's financial stability.

A. The Supported Living Standards and Procedures outlines the responsibilities of the Supported Living providers in regards to vacancies.

<http://www.oregon.gov/dhs/spd/provtools/dd/dd51.pdf> .

Q. We currently have an individual in Supported Living who is diabetic. In order to meet the monitoring needs related to his diabetes we have him call us two times a day seven days a week to report his glucose levels. We have been told that we can only count the face to face hours for Supported Living, however we serve this individual at least a half hour a day seven days a week by phone. Are we allowed to count these hours in to billable time or not?

A. Rule does not require that all Supported Living support hours be face-to-face with the individual. The ANA captures direct support needs, however some of those needs may be met through remote contact (telephone). The situation that is described appears to be providing for the individual's direct needs in the least restrictive and allowing for the most independence for the individual. The individual's ISP should designate how the individual wants his needs met. If it reflects that he wants to have this need met by the Supported Living provider through a twice daily phone contact it is an allowable support for Supported Living funding.

Waivered Supports

Q. Please clarify/explain employment-related Waiver supports – tier levels and how to determine how many hours are available per customer.

A. Tier assignments and rates are outlined in policy transmittal APD-PT-14-023. The amount of support hours available is identified during the ISP process and subject to the limits outlined under OAR 411-345.

Q. Is it ok to authorize the new waiver services?

A. While the waiver amendments have not been approved by CMS, it is still allowable to authorize the services. CMS is aware that Oregon has authorized and been providing the new services within the submitted amendments.

Q. When are waiver or k-plan services terminated when an individual enters an institutional setting?

A. Waiver or k-plan service payments are terminated to the provider according to the Standards and Procedures for the service element the individual is enrolled in. The timeframes vary among service elements and type of institutional stay.

However, if the individual is not being terminated from the service and as long as the Level of Care remains active the individual remains eligible for that service when they exit the institution. For k-plan services the Level of Care remains active up to three months from the date that the last k-plan service was received. For waiver services the Level of Care remains active one month from the date the last waiver service was received. Further guidance on institutional stays will be available in the future.

Q. How do Service Coordinators or Personal Agents know if an individual is eligible for OSIPM due to the 300% rule, presumptive eligibility (PMDDT), or not deeming parental income?

A. The most reliable way to determine the financial eligibility of an individual is to contact the APD/SPD office that the individual is assigned to.

In eXPRS there are codes that indicate the different categories of financial eligibility however this may be out-of-date therefore if there is any question about the OSIPM eligibility follow up with the APD/SPD office that determined eligibility for the individual.

Q. An individual has recently enrolled in Brokerage for case management and is not on the waiver. The individual is requesting waiver services, how is the individual enrolled into a waiver service?

A. The PA should verify that the individual is OSIPM eligible or assist the individual in applying for OSIPM if needed. The PA should complete a Level of Care if there is not a current Level of Care (unexpired). The PA will complete the assessment and planning process including waiver services that are requested in the individual's ISP. The PA will submit a 4111 to the CDDP indicating the effective date of enrollment into the waiver services.

Waiver services may begin on or after the date that the LOC, assessment, and ISP are all completed. Please follow the timelines for completion of those components that are in OAR.

Q: Is Foster and Residential under K plan now or is that still under the Waiver?

A: Foster care homes and 24 hour group homes are both service settings in which ADL/IADL support (attendant care) is provided. ADL/IADL supports are from the K plan.

ReBar

Q. CDDP managers reported that they used to receiving Tier 7 Memo's regarding tier review outcome, and now they are not getting these. Can that be reinstated?

A. Tier review outcomes are being sent out via email—They are sent to the SC and the designated recipient on record from the CDDPs. Usually w/in one week.

Oregon Administrative Rules (OARs)

Q. For the Oregon Administrative Rule changes taking effect at the end of December, 2014, will there be training available?

A. ODDS are coordinating separate PowerPoint trainings by topic. The trainings will be via conference line on a weekly basis. A schedule of the trainings will be available towards the end of October. Trainings will begin November 12th and go through mid-January if needed.

Q. Do all complaints (regardless of how they are received), that are received by a CDDP or brokerage, need to be entered or logged in the programs complaint log?

A. Complaints about the CDDP or Brokerage should be entered into the programs complaint log, identifying the elements required by rule. Complaints regarding personnel issues and allegations of abuse must be maintained separately from the complaint log. Complaints submitted based on a dissatisfaction with services, services providers or circumstances that are contrary to law, rule or policy, may need to be logged based on the level of intervention.

For example:

- Complaints which require a response from a CDDP program manager/Brokerage director must be entered in the complaint log.
- If a formal process such as an ISP meeting, CDDP program manager or Brokerage Director intervention, or a written response answering a question or providing clarity is required, then the complaint would be logged in the complaint log, including all the elements required by rule.
- If the complaint can be resolved via problem solving with the Services Coordinator or Personal Agent, it does not need to be logged. However, progress noting that intervention must be recorded via progress notes in the person's file.

Q. How long does the CDDP have to keep the applications for DD services of denied clients?

A. The CDDP OAR 411-320-0070 on service records requires CDDPs to have a record retention plan that is consistent with the County retention schedules listed in OAR 166-150-0055.

OAR 166-150-0055(2)—Developmental Disabilities Intake Reports: Series documents the initial contact with a potential client in order to determine if the person is eligible for developmental

disability programs. Series may include records such as an information sheet; application; signed release forms for other records such as school records, psychological reports, social security, and skill assessments; progress notes; letter of decision; and appeals of the decision. If the person is eligible for service, the intake report file becomes part of the Developmental Disabilities Service Records. (Minimum retention: (a) If eligible for DD programs: Transfer to Developmental Disabilities Service Records (b) All other cases: 10 years)

OAR 166-150-0055(3)—Developmental Disabilities Service Records: Series documents services provided to persons with developmental disabilities. This county agency is the entry point for all developmentally disabled eligible persons and determines the needs and appropriate programs for the client. Services include intake and case management, crisis services, and family support services. Services such as residential, vocational, and transportation services, may be contracted out. Information contained in the records may include applications for service; referrals; progress notes; medical records; individual service plans (ISP); diagnostic and evaluation results; and financial and legal records. (Minimum retention: (a) Individual Service Plans: 10 years (b) All other records if death date is known: 7 years after date of death (c) All other records if case is closed, inactive, or death date is unknown: 70 years)

Behavior Consultation

Q. What is Behavior Consultation?

A. *Behavior Consultation* is a service where a qualified consultant identifies strategies to address behaviors that are unsafe or impact a person's ability to have his/her basic needs met. This service is often time-limited where a consultant will be engaged to target specific behaviors and may also provide brief follow up support to a caregiving team, such as training or modifications to a plan. In some situations, a consultant may be engaged to work with an individual's team ongoing to address exceptional needs.

Q. Who is a Behavior Consultant?

A. A *Behavior Consultant* is a human service professional with education, experience and specialized training that qualifies them as an expert related to functions of human behavior. Consultants have a strong background related to working in the field of Developmental Disabilities services.

Q. Who may be contracted to provide Behavior Consultation service?

A. Any willing Medicaid provider who meets the qualifications of a Behavior Consultant (as stated in Oregon Administrative Rules and in alignment with the Provider Enrollment Agreement) and completes and meets the requirements of the Consultant Provider Enrollment Agreement may be a provider of Behavior Consultation services. Behavior Consultants are considered either an independent contractor (IC) or work under an agency.

Q. What is expected from Behavior Consultation?

A. A behavior consultant will work with an individual service recipient and other supportive persons in the individual's life to gather information about unsafe, challenging behaviors. This process includes identifying what the behaviors are, what may be causing, contributing to, or reinforcing the maladaptive behavior, as well as learning more about the individual to identify what may be important to and successful for the individual. Knowing more about what is important to an individual and about a person's routines and interests is a key to a consultant understanding more about the behavior and helping to identify strategies. This information is put together into a Functional Behavior Assessment which is a written document or report that explains what the consultant has learned about the individual and his/her behavior.

After learning more about the behaviors through the Functional Behavior Assessment process, the team may have a better idea of what the most appropriate type of plan or behavior support tools would be for an individual situation. This additional consultation may include a formal Behavior Support Plan or Interaction Guidelines.

Q. Is Behavior Consultation a direct or indirect support?

A. Behavior Consultation is primarily directed at the caregivers or persons supporting an individual in meeting the individual's basic health, safety and personal care needs. The intent with application of behavior consultation in a services plan is that the consultation will provide guidance and structure that may be carried forward by a caregiver or the individual themselves to aid in improving health and safety.

An individual should be as directly involved as possible in the process of utilizing behavior supports. It is important for the consultant to have input from an individual about their perspective of the behaviors as well as what is important to the individual and what the individual finds most helpful or successful in being supported. This may also include assistance to an individual in identifying how supportive persons in their life can help them use their plan and initial training to help the individual understand their behavior strategies. However, a consultant should not be the party providing direct support to implement the plan strategies with the individual.

The direct support to provide ongoing training to an individual to address behaviors or implement strategies is considered direct care or skills training. If the individual has an identified assessed need for direct support, the individual may receive funding to hire direct care staff to help implement behavior strategies. An individual may elect a behavior consultant to be the care provider that delivers direct support, however, the direct support activities would not be considered "behavior consultation". The provider would need to be enrolled as a personal support worker (PSW) or attendant care independent contractor (IC) and compensation for the

time providing the direct care or skills training would be at the attendant care rate, not at the service rate for behavior consultation.

Q. Can a Behavior Consultant also be a paid direct support provider or PSW?

A. Any person that meets the qualifications of a direct support provider or PSW may work in the role of a direct support caregiver or PSW. A provider may have multiple roles in the Developmental Disabilities service system. For example, a behavior consultant may also be a direct support provider as an IC (Independent Contractor) or PSW (Personal Support Worker). In the situation where a Behavior Consultant is also providing services in the capacity as an attendant care provider and is the only PSW or direct support provider, ODDS would want to ensure there is no conflict of interest inherent in this arrangement. The individual's Individual Support Plan needs to address potential conflict of interest where a person serving in a capacity may influence the amount and type of services included in an ISP while also serving as a paid provider for those services.

The provider's role and compensation are determined by the duties they are performing in supporting the individual and in accordance with the ISP. A provider must have a provider enrollment agreement for each discrete role they are performing in providing services. In the example of the Behavior Consultant who is also a direct care PSW- the provider would have a provider enrollment agreement and provider number as a Behavior Consultant and a separate provider enrollment agreement and provider number as a PSW. Direct care provided to the individual would be compensated at the attendant care service rates.

Q. What is not included in Behavior Consultation?

A. Behavior Consultation is not counseling or therapy and does not replace direct care support. This means that a behavior consultant will be primarily working with the caregivers who do support the individual. The behavior consultant creates a plan and provides training to the care providers so that an individual may be supported ongoing in their daily care; or creates a plan and strategies that an individual may then implement independently or with supports the individual identifies.

A Behavior Consultant's scope of work includes providing training and guidance to caregivers so the caregiver is the party that is directly addressing identified behaviors, implementing strategies and working with the individual on skill building related to their behavior supports and care needs. The consultant may also provide initial training of a plan to an individual so that the individual may understand the plan and identify resources to assist in the continued implementation of strategies. The initial training is not skill training nor support to implement the strategies.

For individuals, caregivers and family members who are desiring a more intensive or direct service relationship related to coping with care challenges, the services coordinator or personal agent should work with these parties in identifying resource options to meet their needs. This

may include assistance with accessing mental health or behavioral health services through an individual's medical card or community program, help in identifying support groups or networks, and assisting the individual and their family in planning of supports to explore direct care provider options.

Q. How does behavior consultation work for an individual who does not have direct care supports identified in their individual support plan?

A. An individual who is eligible to receive behavior consultation when it is identified as an assessed need, may elect to receive the service regardless of whether the individual's plan includes direct care supports (paid or unpaid). It is possible to provide behavioral consultation to a customer when they do not have any direct care providers if the individual is able to learn and gain from the consultation. If the customer requires on-going direct care, connect the customer with the brokerage or the CDDP to help the customer identify whether they are eligible for attendant care hours of support.

A consultant may not provide direct care support to the individual (including emotional support and coaching) to implement a plan or behavior strategies as a result of a lack of direct care supports. The individual should be encouraged to work with their personal agent or services coordinator in seeking assistance in developing a plan which includes direct support

Q. Who may a consultant bill for services? For what?

A. A consultant provider may only bill for consultation services that have been prior authorized in an individual's ISP (Individual Support Plan). The ISP should identify details about the service included its intended use and delivery. Services performed outside the parameters set in the ISP are not billable as a Medicaid service. The consultant may also not bill for services that are outside the scope of a consultant's duties, such as those that activities that may be completed by a direct support staff (such as skills training, coaching and support to implement strategies) or other activities that would be considered to be beyond consultation (such as time spent attending school meetings, advocacy activities, providing emotional support).

A consultant may establish a business model that includes private practice and private pay services. ODDS does not conduct oversight over private practice and private pay arrangements.

Q. What is "social-sexual consultation"?

A. "Social-sexual consultation" is not a currently defined service offered through Oregon's Developmental Disabilities Program services. It is not included in Oregon Administrative Rule language and is not a specific service offered in Oregon's Medicaid 1915 waivers, nor in the Community First Choice (k-plan) state plan services. "Behavior Consultation" is a service that can address a wide array of behaviors that are unsafe or impact an individual's ability to have their basic needs met. The behaviors addressed through

consultation may include those that are sexual in nature. Any behavior consultation services performed in Oregon must follow service rules, align with Positive Behavior Theory and Practice and should have documentation produced (such as a functional behavior assessment, behavior support plan, interaction guidelines, etc.).

Q. What about the Sex Offender Treatment Provider option listed on the Consultant Provider Enrollment Agreement? Can “Social-Sexual Consultation” be provided under this category?

A. No, “Social-Sexual Consultation” is not a service that is offered through the Office of Developmental Disability Services (ODDS). The Sex Offender Treatment Provider option is limited to only those professional providers who meet the requirements of OAR Chapter 331, division 810 and ORS 675.375. This requires the sex offender treatment provider to be certified as a clinical sex offender therapist. The services provided by this provider type are strictly limited to court-mandated sex offender treatment that is authorized as a general fund expenditure by ODDS administration.

Q. Is a consultant an employee of the State of Oregon or ODDS?

A. No, a behavior consultant is a contracted vendor that is elected or “employed” by the individual who is eligible for services funding on their behalf. The consultant is required to meet minimum qualification requirements and provide insurance coverage associated with conducting business. The state of Oregon does not select or employ the contractor of Behavior Consultation Services. It is the role of ODDS as Medicaid program entity to ensure that providers of service meet minimum standards for qualifications, liability and service delivery. It is also the role of ODDS to administer and provide oversight related to service eligibility and authorization of services. Individuals who are eligible for specific services may elect qualified, enrolled providers to deliver the service. It is within the scope of authority of the Medicaid program to determine how a service is authorized and to have oversight over the service delivery being funded.

Q. Who should a Behavior Consultant contact if they have service delivery questions?

A. Behavior Consultants should contact the personal agent, services coordinator or program manager of the case management program they are working with.

Q. Who should the Services Coordinator or Personal Agent contact if they have service delivery questions?

A. The services coordinator or personal agent should consult first with their CDDP program manager or Brokerage Director with questions. The program manager or director (or SC/PA at the direction of their manager) may then contact ODDS if further clarification or guidance is needed.