DHS Oregon Department of Human Services

Seniors and People with Disabilities

Action Request Transmittal

Cathy Cooper
Authorized Signature

Number: **SPD-AR-10-049**
Issue Date: 6/9/2010

Topic: Developmental Disabilities

Due Date: September 15, 2010

Subject: 2009 TXIX HCBS Waiver Review Checklist and Statewide Sample information

Applies to (check all that apply):

- ☐ All DHS employees
- ☐ Area Agencies on Aging
- ☐ Children, Adults and Families
- ☒ County DD Program Managers
- ☒ County Mental Health Directors
- ☐ Health Services
- ☐ Seniors and People with Disabilities
- ☒ Other (please specify): CDDP QA Coordinators, SS Brokerage Directors, SS Brokerage QA Coordinators, SPD ODDS Staff

Action Required:

The Centers for Medicare and Medicaid Services (CMS) sets specific conditions for participation in Title XIX HCBS Medicaid Waivers. Seniors and People with Disabilities (SPD) and its community partners are responsible to ensure these conditions are met. One required action is that Community Developmental Disability Programs (CDDPs) and Support Services Brokerages must complete file reviews based on a format established by SPD. The reviews involve initial examination of statistically valid, randomly selected samples of CDDP and Support Services Brokerage case files and records for compliance.

CDDP and Brokerage QA Coordinators will identify areas requiring follow up and assure the follow up is completed. The QA Coordinators will be responsible for tracking all required follow up; SPD may request an update on the status.

The prior version of the form had to be changed to meet the requirements of CMS' 6 Assurances. The form has been streamlined to improve clarity, ensure the results are measurable and target the 6 Assurances. There will not be a separate Frequently Asked Questions (FAQ) or Instructions document.

What:

The HCBS Title XIX Waiver Review Project for 2009 has separate checklists for CDDPs and Brokerages. Both checklists focus on questions related to a specific individual's records including, but not limited to: Individual Support Plan (ISP), Monthly Monitoring Checklists,

Title XIX Waiver Form, Provider Qualifications, Incident Reports and Eligibility Documentation. The Provider Qualification section focuses on compliance of providers in meeting the requirements of Oregon Administrative Rule. Dependent upon each CDDP or Brokerage process, this information might be located in a provider file or an individual's record.

The HCBS Waiver Review Checklists (CDDP or Brokerage) will be used to document each review and are attached to this Action Request.

When:

The official start date of the project is June 15, 2010. All CDDP and Brokerage Checklists must be submitted by 5:00 PM on September 15, 2010. The checklists may be submitted via e-mail, first class mail or fax.

Who:

SPD has chosen a statistically valid, random sample of individuals who received waiver services during the 2009 calendar year to be included in this statewide review. Based upon the truly random sample, some CDDPs and Brokerages may not receive a list of files to review this year. Notification will be given to offices that are not required to participate in the review because there are no individuals selected from those offices.

How:

The Checklists will be used to answer questions for each individual selected for the five waiver samples. The checklist is available in hard copy only. The final data must be submitted to SPD via e-mail, first class mail or fax.

The individual checklists will be returned to each reviewer on a regular basis. They will be returned by email as a PDF document. The email will be encrypted to ensure all data is secure.

Upon completion of the review, an excel file of all the data entered for a specific CDDP or Brokerage will be made available.

Reason for Action: CMS requires SPD to collect, analyze and act upon information to maintain and improve quality in waiver services. SPD has made contract arrangements to support statewide and local waiver quality assurance processes through specific resources located in CDDPs and Brokerages. This random sample review of individual files is a primary means of assessing SPD compliance with basic Medicaid requirements for individuals' waiver services.

Field/Stakeholder review: ☒ Yes ☐ No

If yes, reviewed by: **CDDP QA Coordinators**

If you have any questions about this action request, contact:

Contact(s):	Dana Hittle		
Phone:	503-945-5810	**Fax:**	503-373-7274
E-mail:	dana.hittle@state.or.us		

HCBS Waiver Review Checklist - 2009

Directions: The review period is January 1, 2009 through December 31, 2009. Use the plan and other documentation that covered the majority of the 2009 calendar year to answer the questions. This may require reviewing information from the 2008 calendar year. For example, in the 2008 calendar year the Individual Support Plan (ISP) effective date was 10/1/2008, then use the 10/1/2008 ISP to complete the review. The 10/1/2008 ISP would have covered the majority of the 2009 calendar year. If you have questions regarding this checklist or the review contact the SPD Quality Assurance Coordinator at 503-945-5810.

Individual's First Name | **Individual's Last Name** | **Prime #**

Waiver Enrolled in 1/09-12/09 | **Service Coordinator's Name**

CDDP or SPD Office Name

Review Date | **Reviewer's Name** | **Reviewer's Email**

PART I: Annual Individual Support Plan Review

Response

1. Was the individual's annual plan current during the review period?

If YES, skip to Part I.3.

2. If the individual's annual plan covering the review period was not current, was the reason documented?

3. Select the waiver service(s) received during the review period:

Services Received

a. Children's Intensive In-Home (Behavorial)	
b. Children's Intensive In-Home (MFCU)	
c. Children's Intensive In-Home (MICW)	
d. Comprehensive In-Home	
e. Employment/Alternatives to Employment	
f. SPD DD-Licensed Foster Home (under 18)	
g. SPD DD- Licensed Foster Home (over 18)	
h. Supported Living	
i. 24-Hour Residential	

4. Were the waiver services received during the review period consistent with the individual's plan?

5. Did the individual's records reflect a discussion of necessary evaluations or assessments?

If NO, then skip to Part I.6

Note: The discussion might be addressed in the following documents; annual plan, mtg. notes, risk tracking record, monthly monitoring, or other records. The most common reasons for requesting an evaluation or assessment are to identify health risks, safety risks, and behavioral support needs. The evaluations and assessments may lead to protocols or plans of support.

Response

5a. If the need for an evaluation or assessment was identified, was there documentation it was completed within the specified time line?

6. Did the individual's annual planning process reflect the individual's preferences?

Note: Annual planning process could include personal focus worksheet, risk tracking record, ISP agenda, ISP, or other documentation.

6a. If the individual's preferences were not incorporated into the annual plan, did the ISP Team discuss the reason during the annual planning process?

Answer Options: Not Applicable, Yes, or No.

Part II: Monthly Monitoring Review

Response

1. Was the individual residing at an adult foster home (AFH) or 24-hour residential setting during the review period?

If NO, skip to Part III.1.

1a. Did the individual reside at the AFH or 24-hour residential setting for six months or more during the identified plan period (see directions for explanation on "plan period")?

If NO, skip to Part III.1.

Note: If an individual resided at more than one AFH or 24-hour site during the plan period include all the months for each provider. For example, Jon Doe lives at provider ABC 10/12/2008 to 2/01/2009 and provider XYZ 2/2/2009 to 5/28/2009 the answer would be YES.

2. Was the Behavior Service Review Checklist completed within 6 months of the individual's annual plan?

Note: The checklist would need to be completed by the last day of the sixth month following the ISP. For example, ISP effective 10/12/2008 then checklist must be completed by 4/30/09.

3. Was the Medical Service Review Checklist completed within 6 months of the individual's annual plan?

4. Was the ISP Service Review Checklist completed within 6 months of the individual's annual plan?

	Response
5. Are addenda to current ISP present documenting changes and adjustments?	
6. How many times was the Financial and Personal Property Checklist completed within 12 months of the individual's annual plan?	

Answer Options: Not Applicable, Yes, or No

PART III. Title XIX Waiver Form Review

Note: Some of the older Title XIX Waiver Forms used for the initial review of level of care did not have all of the fields listed in III.2a-f. If the older version does not have a specific field, DO NOT consider the form incomplete, unless a field that is present is left blank.

	Response
1. Were any of the items listed below left blank on the initial Title XIX Waiver Form?	

If NO, skip to Part III.3.

2. Check all that apply:

a. Missing Individual Signature (If own guardian)	a.
b. Missing Diagnosis and Evaluation Coordinator or SPD Medical Director Signature	b.
c. Missing Guardian or Legal Rep. Signature (If Individual is not their own legal guardian)	c.
d. Missing Services Coordinator's signature	d.
e. No evidence of Hearing Rights Offered	e.
f. No evidence of Offering of Choice between Home and Community Based Care and care in an ICF/MR, Nursing Facility or Hospital	f.

3. In the calendar year of 2009, was the annual ongoing verification of need for ICF/MR, Hospital or Nursing Facility level of care completed within twelve months from the previous level of care determination and within 60-days of the individual's annual plan?	

Note: The LOC must be completed within 60-days of the individual's annual plan.

PART IV: Eligibility Determination Review

Note: The purpose of this section is to verify the presence of the below-listed documents only. Please do not use this checklist to question the eligibility decision of the Eligibility Specialist or SPD's D & E Coordinators. DD Eligibility is required for enrollment into the Comprehensive, Support Services and Behavioral Model Waivers. For children on the Behavioral Model Waiver, please answer the questions related to DD Eligibility and CIIS eligibility criteria.

Response

1. Mark the criteria used for this individual's DD eligibility:

Answer Options: Mental Retardation (MR), Developmental Disability Only (DD), or under MFCU, CIIS or MICW Criteria.

2. Does the individual's file contain a completed Eligibility Statement prior to July 2009, or, a completed Eligibility Notice after July 2009?

3. Was the MFCU, CIIS or MICW eligibility criteria for the time period under review in the individual's case record (including any required re-evaluations)?

Answer Options: Not Applicable, Yes, or No.

Part V. Complaint, Grievance, and Fair Hearing

Response

1. Was there documentation that the individual was made aware of their Complaint, Grievance and Fair Hearing Rights during the 2009 calendar year?

2. Have there been any complaints, grievances or request for a Fair Hearing made by the individual, family or others during the 2009 calendar year?

If NO, Skip to Part VI.

3. Were the complaint(s), grievance(s), or Fair Hearing(s) resolved?

Answer Options: Yes, No, Pending Fair Hearing

Note: If more than one complaint, grievance, or Fair Hearing is identified answer Yes if all have been resolved. If only some have been resolved then answer No or Pending Fair Hearing, which ever is applicable.

Part VI. Qualified Providers

	Response
1. Non-Licensed or non-certified providers identified in the individual's annual plan adhered to OAR qualification requirements during the review period.	
2. Providers identified in the individual's annual plan, that required licensure and/or certification under OAR, initially met and continue to meet qualification requirements.	

Answer options: Not Applicable, Yes, or No

Part VII. Health and Safety

	Response
1. Individual was the victim of substantiated abuse, neglect or exploitation during the review period?	
If NO, skip to Part VIII.	
2. Protective service actions were taken and substantiated incidents of abuse, neglect or exploitation were addressed during the review period.	

Part VIII. Remediation

	Response
1. Corrections Required?	

If NO, skip to Part IX.

2. Sections Needing Remediation (Check all that apply)

I. Annual Individual Service Plan Review	
II. Monthly Monitoring Review	
III. TXIX Waiver Form Review	
IV. Eligibility Determination Review	
V. Complaint, Grievance and Fair Hearings Rights Review	
VI. Qualified Providers	
VII. Health and Safety	

	Response
3. Checklist findings reported to:	
4. Date all corrective actions to be complete:	
5. Corrective actions reviewed by:	
6. Date reviewed:	

Part IX. General Notes

HCBS Waiver Review Checklist - 2009

Directions: The review period is January 1, 2009 through December 31, 2009. Use the plan and other documentation that covered the majority of the 2009 calendar year to answer the questions. This may require reviewing information from the 2008 calendar year. For example, in the 2008 calendar year the Individual Support Plan (ISP) effective date was 10/1/2008, then use the 10/1/2008 ISP to complete the review. The 10/1/2008 ISP would have covered the majority of the 2009 calendar year. If you have questions regarding this checklist or the review, contact the SPD Quality Assurance Coordinator at 503-945-5810.

Individual's First Name **Individual's Last Name** **Prime #**

Brokerage Name **Personal Agent's Name**

Review Date **Reviewer's Name** **Reviewer's Email**

PART I: Annual Individual Support Plan Review

Response

1. Was the individual's annual plan current during the review period?
If YES, skip to Part I.3.

2. If the individual's annual plan covering the review period was not current, was the reason documented?

3. Were the waiver services received during the review period consistent with the individual's annual plan?

4. Did the individual's records reflect a discussion of necessary evaluations or assessments?
If NO, then skip to Part I.5

Note: The discussion might be addressed in the following documents; annual plan, mtg. notes, risk tracking record, customer goal survey, or other records. The most common reasons for requesting an evaluation or assessment are to identify health risks, safety risks, and behavioral support needs. The evaluations and assessments may lead to protocols or plans of support.

Response

4a. If the need for an evaluation or assessment was identified, was there documentation it was completed within the specified time line?

5. Did the individual's annual planning process reflect the individual's preferences?

Note: Annual planning process could include goal survey, personal focus worksheet, risk tracking record, ISP agenda, ISP, or other documentation.

5a. If the individual's preferences were not incorporated into the annual plan, is there documentation of discussion with the customer as to why the preferences were not incorporated?

	Response
6. Were changes to the individual's annual plan recorded on either the ISP or amendment?	

Answer Options: Not Applicable, Yes, or No.

PART II. Title XIX Waiver Form Review

Note: Some of the older Title XIX Waiver Forms used for the initial review of level of care did not have all of the fields listed in II.2a-f. If the older version does not have a specific field, DO NOT consider the form incomplete, unless a field that is present is left blank.

	Response
1. Were any of the items listed below left blank on the initial Title XIX Waiver Form?	

If NO, skip to Part II.3.

2. Check all that apply:

a. Missing Individual Signature (If own guardian)	a.
d. Missing Diagnosis and Evaluation Coordinator or SPD Medical Director Signature	b.
c. Missing Guardian or Legal Rep. Signature (If Individual is not their own legal guardian)	c.
b. Missing Services Coordinator's or Personal Agent's signature	d.
e. No evidence of Hearing Rights Offered	e.
f. No evidence of Offering of Choice between Home and Community Based Care and care in an ICF/MR	f.

3. In the calendar year of 2009, was the annual ongoing verification of need for ICF/MR level of care completed within twelve months from the previous level of care determination and within 60-days of the individual's annual plan?	

Note: The LOC must be completed within 60-days of the individual's annual plan.

PART III: Complaint Grievance, and Fair Hearing

	Response
1. Was there documentation that the individual was made aware of their Complaint, Grievance, and Fair Hearing Rights during the 2009 calendar year?	
2. Have there been any complaints, grievances or request for a Fair Hearing made by the individual, family or others during the 2009 calendar year?	

If NO, Skip to Part IV.

3. Were the complaint(s), grievance(s), or Fair Hearing(s) resolved?	

Answer Options: Yes, No, Pending Fair Hearing

Note: If more than one complaint, grievance, or Fair Hearing is identified answer "Yes" if all have been resolved. If only some have been resolved then answer "No" or "Pending Fair Hearing," which ever is applicable.

Part IV. Qualified Providers

	Response
1. Non-Licensed or non-certified providers identified in the individual's annual plan adhered to OAR qualification requirements during the review period.	
2. Providers identified in the individual's annual plan, that required licensure and/or certification under OAR, initially met and continue to meet qualification requirements.	

Answer options: Not Applicable, Yes, or No

Part V. Health and Safety

	Response
1. Individual was the victim of substantiated abuse, neglect or exploitation during the review period?	
If NO, skip to Part VI.	
2. Protective service actions were taken and substantiated incidents of abuse, neglect or exploitation were addressed during the review period.	

Part VI. Remediation

	Response
1. Corrections Required? **If NO, skip to Part VII.**	

2. Sections Needing Remediation (Check all that apply)

I. Annual Individual Service Plan Review	
II. TXIX Waiver Form Review	
III. Complaint, Grievance and Fair Hearings Rights Review	
IV. Qualified Providers	
V. Health and Safety	

	Response
3. Checklist findings reported to:	
4. Date all corrective actions to be complete:	
5. Corrective actions reviewed by:	
6. Date reviewed:	

Part VII. General Notes