

2021 - 2023

Collective Bargaining Agreement



Between
The Department of
Administrative Services,
on Behalf of the State of
Oregon

And

Service Employees
International Union
Local 503, Oregon Public
Employees Union:
Adult Foster Home Providers



Adult Foster Home Providers

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ARTICLE 1 – PARTIES TO THE AGREEMENT

This Agreement is made and entered into at Salem, Oregon, pursuant to the provisions of the Oregon Revised Statutes, by and between the State of Oregon, hereinafter referred to as “the STATE”, through the Department of Administrative Services (DAS), the Oregon Department of Human Services (DHS) and the Oregon Health Authority (OHA) hereinafter known as “the State” and the Service Employees International Union (SEIU) Local 503, OPEU hereinafter referred to as “the UNION” and jointly hereafter referred to as “the PARTIES”.

It is the purpose of this Agreement to achieve and maintain harmonious relations between the STATE and the UNION, to provide for equitable and peaceful adjustments of differences which may arise.

ARTICLE 2 – RECOGNITION

2.1 EXCLUSIVE REPRESENTATIVE

The State recognizes the Union as the exclusive representative for a single strike-prohibited bargaining unit consisting of all eligible licensed Adult Foster Home Providers as listed in Section 2 of this Article.

2.2 BARGAINING UNIT DEFINITION

The bargaining unit consists of all Adult Foster Home Providers as defined in this Section, excluding substitute caregivers, employees of the Provider and Providers who do not live in one of their adult foster homes and other employees excluded from the protection of the Public Employee Collective Bargaining Act.

- A. For purposes of this Agreement, the term "Adult Foster Home Provider" means:
- (I) any natural person who:
 - (i) is licensed to and provides adult client services in and lives in the Provider's home; and
 - (ii) receives service payment from any state funds under Department of Human Services/Oregon Health Authority Adult Foster Home Programs or State funds that are passed through outside contractors and/or counties to pay the Provider.

 - (II) any natural person who:
 - (i) is licensed to and provides adult client services in and lives in the Provider's own home; and

- (ii) owns a controlling interest in, or is an officer or partner of, an entity (e.g., corporation, Limited Liability Corporation (LLC) or partnership) that receives service payment from state funds under Department of Human Services/Oregon Health Authority Adult Foster Home Programs for services provided in such Provider's own home or State funds that are passed through outside contractors and/or counties to pay Provider.

B. For purposes of this Agreement, the following definitions apply:

- "own home" means one's full-time domicile that is the licensed Adult Foster Home and where the Provider customarily and regularly conducts his or her activities of daily living, e.g., sleeping, eating, bathing, and recreating at that domicile. This language does not mean that the Provider is required to be present twenty-four (24) hours a day or seven (7) days a week, but rather is meant to clarify that a Provider resides on a full-time basis with a state-funded resident at that licensed domicile.
- "partner" means an individual who, with one or more other persons, is co-owner of a business for profit (ORS 67.005(7)).
- "officer" means a corporation's president or secretary and other officers not to exceed a total of three (3) for the corporation.
- "controlling" means a majority interest in the Provider entity.

2.3 BARGAINING UNIT MODIFICATIONS

When there has been a determination of the Employment Relations Board to modify the bargaining unit listed in Section 2 of this Article or when the Parties reach mutual agreement to modify, negotiations will be entered into as needed or as required by law.

ARTICLE 3 – TERM OF AGREEMENT

3.1 EFFECTIVE DATE.

Unless otherwise noted in a specific article in the Agreement, this Agreement becomes effective on the date of ratification and expires June 30, 2023. The Union shall send a communication informing the Department of Administrative Services Labor Relations and the affected Agencies of the specific ratification date of the tentative agreement. If the Union does not send the communication identifying the date of the ratification vote, the Employer will use the effective date of the Agreement as being the first of the month following the date of signature.

3.2 NOTICE TO NEGOTIATE.

Either party may give written notice no less than one hundred and eighty (180)-days preceding the expiration of the Agreement of its desire to negotiate a successor Agreement.

3.3 COMMENCING NEGOTIATIONS.

Negotiations for a successor agreement shall commence during the first (1st) full week of March 2023, or such other date as may be mutually agreed upon, in writing, by the Parties. The Parties shall present any proposed changes desired in a Successor Agreement by the beginning of the second (2nd) meeting.

3.4 SCHEDULING NEGOTIATIONS.

During the first (1st) meeting, the Parties agree to schedule at least two (2) negotiating dates per month for April, May, June and July unless mutually agreed upon otherwise, in writing, at that meeting.

3.5 MEDIATION AND BINDING ARBITRATION.

Either Party may invoke mediation on or after June 30th of 2023 and any subsequent bargaining session shall include the Mediator on dates mutually agreed to by the Parties

and the Mediator. Thereafter, the time lines and procedures set out in ORS 243.712 and 243.742 shall apply unless the Parties mutually agree, in writing, otherwise.

3.6 AGREEMENT EXTENSION.

If the Parties fail to reach agreement on a new successor Agreement on or before June 30, 2023, the Agreement shall be automatically extended until a new Agreement is reached or an opinion and order is promulgated pursuant to ORS 243.746(5).

3.7 PROCESS TO OPEN AGREEMENT DURING TERM.

No opening of this Agreement may take place unless specifically authorized herein or by mutual agreement, in writing, by the Parties or by operation of law.

REV: 2021

ARTICLE 4 – COMPLETE AGREEMENT

4.1

Pursuant to their statutory obligations to bargain in good faith, the State and the Union have met in full and free discussion concerning matters in “employment relations” as defined by ORS 243.650(7). This Agreement incorporates the sole and complete agreement between the State and the Union resulting from these negotiations.

4.2

The Parties recognize the full right of the State to issue rules, regulations and procedures and that these rights are diminished only by the law and this Agreement, including interpretative decisions which may evolve pursuant to the proper exercise of authority given by the law or this Agreement.

4.3

The State agrees to bargain over any change(s) it proposes to make to mandatory subjects of bargaining not covered by the Agreement pursuant to the Public Employee Collective Bargaining Act (PECBA). Changes to any of the terms and conditions contained in the Agreement may be made by mutual agreement or as otherwise allowed by ORS 243.698 or ORS 243.702.

4.4

The Employer agrees to bargain if there is an increase in state or federal funding that can be directed towards Adult Foster Home Providers during the term of this Agreement if the State has the authority to use the funds for Provider service payments or benefits. Such negotiation shall follow the timelines pursuant to ORS 243.698. After the ninety (90) day period of negotiations either Party may declare impasse and proceed to binding arbitration in accordance with ORS 243.742.

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ARTICLE 5 – SEPARABILITY

In the event that any provision of this Agreement is at any time declared invalid by any court of competent jurisdiction, declared invalid by final Employment Relations Board (ERB) order, made illegal through enactment of federal or state law or through government regulations having the full force and effect of law, such action shall not invalidate the entire Agreement, it being the express intent of the Parties hereto that all other provisions not invalidated shall remain in full force and effect. The invalidated provision shall be subject to re-negotiation by the Parties within a reasonable period of time from either Party's request.

ARTICLE 6 – UNION RIGHTS

6.1 BULLETIN BOARDS

The Union shall be allowed to provide and maintain a bulletin board or share space on an existing bulletin board in an area regularly accessible by the Provider where space is deemed available by the Adult Foster Care and Relative Adult Foster Care Providers and the local field representatives (DHS/OHA or Area Agencies on Aging (AAA), or Community Mental Health Program (CMHP)), or the Community Developmental Disability Program (CDDP). Such space shall not be denied for arbitrary or capricious reasons.

6.2 UNION PRESENTATION AT TRAININGS AND ORIENTATIONS

The Union shall be granted thirty (30) minutes to discuss Union business at all scheduled training, continuing education trainings, and scheduled group orientations for Adult Foster Home Providers or persons interested in becoming Adult Foster Home Providers. For group orientations, the Union shall be permitted the thirty (30) minutes, at the beginning or end of the scheduled orientation, at a mutually agreeable time. For trainings and continuing education trainings, unless time during the training has been mutually agreed to, time and space will be available before or after the training.

The State shall notify the Union via email at least fifteen (15) days prior to a scheduled formal training and group orientations for Adult Foster Home Providers or persons interested in becoming Adult Foster Home Providers.

Any contract that the State enters into with any organization to which it has targeted Adult Foster Home training responsibilities shall include the requirements listed above in Section 6.2.

6.3 UNIQUE IDENTIFICATION NUMBER

The State shall ensure that each contracted Adult Foster Care Provider in the bargaining unit is assigned a unique identification number based on their tax ID number. This number shall consistently be used to identify the Provider whenever the Provider is

enrolled for payment within the Adult Foster Care bargaining unit as long as the Provider uses their same tax ID number. This number will be used for SEIU reporting regardless of the Provider numbers in the State payment system.

6.4 LIST AND INFORMATION

By the tenth (10th) calendar day of each month DHS/OHA shall transmit an electronic file of all Adult Foster Home Providers in the bargaining unit that have a Provider Enrollment Agreement with and received payment from DHS/OHA in the previous month. The file shall include: Service Period Begin Date; Service Period End Date; Provider Unique Identification Number; Number of Medicaid residents; Provider Name; Provider Street Address; Provider Telephone Number; Provider City; State; Zip; Provider e-mail addresses (if available centrally in electronic format); Medicaid payment made by DHS/OHA/State Contractor for each Adult Foster Care resident, to include separately the total service rate and the DHS/OHA/State Contractor-paid portion.

6.5 LIST OF REPRESENTATIVES

The Union shall provide the State with a list of the names of authorized Union staff representatives, elected officers and stewards, and shall update those lists as necessary.

6.6 INDEMNIFICATION

The Union shall indemnify and hold the State or designee harmless against claims, demands, suits, or other forms of liability which may arise out of action taken by the State for the purpose of complying with the provisions of this Article.

6.7 NOTIFICATION OF OAR CHARGES

DHS/OHA will provide notification to the Union at the same time as other interested parties who receive notices of proposed new or modifications to existing OAR. During licensing and renewals, the State will provide Adult Foster Home Providers with information about signing up for alerts regarding OAR updates.

REV: 2021

ARTICLE 7 – GRIEVANCE PROCEDURE

7.1 DEFINITION OF A GRIEVANCE

Grievances are defined as acts, omissions, applications, or interpretations alleged to be violations of the terms or conditions of this Collective Bargaining Agreement.

7.2 INFORMAL RESOLUTION

The Parties encourage, whenever possible, an informal resolution approach between the Adult Foster and local field representatives (DHS/OHA/CCO or Area Agencies on Aging (AAA), or Community Mental Health Program (CMHP), or the Community Developmental Disability Program (CDDP)) over the application of the terms and conditions of the Collective Bargaining Agreement that are within their authority to administer.

If a Provider initiates the informal resolution process, the applicable agencies will notify the Provider of the following process/timelines:

- a) The Informal resolution shall conclude within fourteen (14) calendar days, unless mutually agreed to by the Provider and the local field agency. In the event that the issue is not resolved informally the issue may be formally grieved by either the grievant or the Union.

7.3 GRIEVANCE PROCEDURE

Grievances shall be filed within thirty (30) calendar days of the date the grievant or the Union knows or, by reasonable diligence, should have known of the alleged grievance. Once filed, the Union shall not expand upon the original elements and substance of the written grievance.

Grievances shall be reduced to writing, stating the name(s) of the grievant or grievants; the specific Article(s) alleged to have been violated, a clear explanation of the alleged violation, and the requested remedy. Grievances shall be processed in the following manner:

Step 1.

- a) Grievances shall be filed within thirty (30) calendar days with the DHS/OHA designee.

- b) A Union representative, who may be accompanied by the grievant, shall meet with the DHS/OHA Designee within fourteen (14) calendar days following receipt of the grievance. If the grievance is regarding a pay issue, the meeting shall occur within ten (10) calendar days. The meeting may be in person or via teleconference.

Failure to meet shall not impact the merits of the grievance or its further processing. The DHS/OHA Designee shall respond to the grievance by e-mail no later than fifteen (15) calendar days following the Step 1 meeting or thirty (30) calendar days after the grievance was filed, whichever is sooner. Such response shall state specifically the basis for the Designee's granting or denial of the grievance.

- c) If the grievance is not resolved at Step 1, the Union may appeal the grievance to arbitration by written or e-mail notice to the DHS/OHA Designee within forty-five (45) calendar days of the denial of the grievance by the Director. Failure by the Designee to issue a written disposition of the grievances at Step 1 will permit the Union to invoke arbitration within forty-five (45) calendar days after the Step 1 response was due under the terms of this Article.

Step 2.

Arbitration. The Parties shall meet within thirty (30) calendar days from the date of a tentative settlement being reached on this Agreement to establish a list of five (5) arbitrators. The Employer and the Union shall each designate a representative to reach mutual agreement to establish a list of five (5) arbitrators within thirty (30) calendar days from the date of this package proposal being tentatively agreed to. The Parties will meet to attempt mutual agreement of five (5) arbitrators. If the Parties are unable to reach mutual agreement, then the Parties will strike from the

ERB list of arbitrators, in succession, until five (5) names remain. The five (5) remaining names shall comprise the panel of arbitrators. Within five (5) calendar days of the Union's appeal of a grievance to arbitration, designated representative of the Parties shall confer to designate an Arbitrator to hear the grievances. Arbitrators will be selected from the following list on a rotating basis:

1. Sylvia Skratek
2. Kathryn Whalen
3. Howell Lankford
4. James Lundberg
5. Timothy Williams

Arbitrator List Modifications. The Parties may elect, during periods when the Agreement is open, to modify the list of arbitrators through elimination, addition or replacement. Any such change shall be by mutual agreement, in writing.

Arbitration Scheduling. The Parties shall mutually select dates, provided by the arbitrator for arbitration, in a prompt fashion.

Opinion and Award Timelines. Arbitrators will endeavor to issue a written opinion and award in the grievance within thirty (30) calendar days of the submission of briefs in the case or upon closing of the record if no briefs are filed.

Authority of the Arbitrator. The Arbitrator shall have no authority to rule contrary to, to amend, add to, subtract from, change or eliminate any of the terms of the Agreement. The findings of the Arbitrator shall be final and binding on the Parties. Arbitrations will be handled in accordance with the rules of the American Arbitration Association.

Arbitration Costs. The costs of arbitration shall be borne equally by the Parties. Each party shall bear the cost of its own presentation, including preparation and post-hearing briefs, if any.

Other Complaints, Charges or Claims. Nothing in this Article or Agreement restricts the right of either Party to file complaints, charges, claims or the like with Employment Relations Board or any other State or Federal entity.

Optional Mediations. At any point after a grievance is filed, either Party may request that the matter be submitted to mediation under the rules and procedures of the Employment Relations Board and the Public Employees Collective Bargaining Act (PECBA). Any such submission must be by mutual agreement, in writing. Costs of any agreed to mediation shall be equally shared by the Parties. The conduct of mediation shall not affect the timelines and steps of the grievance process and any change in the timelines and procedures during mediation shall occur only upon mutual agreement, in writing.

7.4 TIME LIMITS

The time limits specified in this Article shall be strictly observed, unless either Party requests a specific extension of time, which, if mutually agreed to, must be stipulated in writing and shall become part of the grievance record. "Filed" for purposes of all steps shall mean date of receipt by mail, hand delivery, by facsimile (fax), email, or as otherwise agreed to by the DHS/OHA designee, and the Union. If the State or its designee fails to issue a response within the time limits, the Union may advance the grievance by written notice to the next step unless withdrawn by the Union. If the Union fails to meet the specified time limits, the grievance shall be considered withdrawn and cannot be resubmitted.

7.5 REPRESENTATIVE COMPENSATION

The State is not responsible for any compensation of Providers or their representative for time spent investigating or processing grievances nor any travel or subsistence expenses incurred by a grievant or Union Steward in the investigation or processing of grievances.

7.6 INFORMATION REQUESTS

Information requests concerning grievances shall be specific and relevant to the grievance investigation. The State or Union will provide the information, to which the requesting party is lawfully entitled, in timely manner. Reasonable costs shall be borne by the requesting party. The requesting party shall be notified of any costs before the information is compiled.

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ARTICLE 8 – NO DISCRIMINATION

8.1 NO DISCRIMINATION DEFINITION AND PROCEDURE

The Union and the State agree not to engage in unlawful discrimination against any Provider because of religion, sex, race, creed, color, national origin, sexual orientation, age, physical or mental disability or Union activities. Written claims of discrimination against the State (DHS or OHA) may be submitted to the Agency Director or designee. The Director or designee will investigate and respond within thirty (30) days of the date of the alleged claim. Discrimination claims may be grieved at Step 2 of Article 7 within fifteen (15) days of receipt of the Director's or designee's response if the response by the Director or designee does not resolve the claim. However, should it be determined that such claims are appealable to the Bureau of Labor and Industries (BOLI) or the Equal Employment Opportunity Commission (EEOC) the appeal shall be submitted to BOLI or EEOC and not subject to the grievance procedure.

8.2 RESIDENT'S RIGHTS

This Article does not apply to the resident's sole and undisputed rights provided in the law, including the selection and termination of placement with a Provider.

8.3 STATE'S AUTHORITY

This Article does not affect the State's (or its designee's) authority, as provided in law, to license and regulate the Provider.

ARTICLE 9 – SERVICE FEES

9.1 SERVICE FEES PREAMBLE

The Parties acknowledge that the State has the authority and right, with appropriate input from the individual resident, Provider, and other assessment team individuals, to assess residents and otherwise determine the particular forms of care and services that are to be provided to each individual resident, and that the assessments of individual residents are not a subject for collective bargaining. However, the Parties agree Provider rates (which are comprised of various component tasks and/or groups of tasks that are given monetary values) are mandatory subjects for collective bargaining, including the legal requirements of notice to and bargaining with the Union and subject only to exceptions recognized by law, while the assessment tools (or any similar other mechanism for calculating Provider rates and their components) are permissive subjects of bargaining as defined by law.

The State will seek to pay Providers reimbursements in accordance with Federal and State laws. Cessation or recoupment of payments to Providers will be addressed under the applicable Federal and State laws. Nothing in this Agreement grants the State any additional rights or means to recoup or cease payment to Providers than otherwise exist in law.

In the event an assessment tool is modified which impacts the way a rate is determined, DHS/OHA shall provide the Union with a copy of the revised tool with written identification of the specific modifications. If either Party believes that the modifications affect rates paid to Providers, they may request negotiation on the rates and other mandatory subjects of bargaining. Such negotiation shall follow the timelines pursuant to ORS 243.698. After the ninety (90) day period of negotiations either Party may declare impasse and proceed to binding arbitration in accordance with ORS 243.742.

9.2 USE OF RESIDENT ASSESSMENT TOOL FOR RATE DETERMINATIONS

- (a) Developmental Disability (DD). The DD assessment and rate setting tool, the SNAP, shall be used for each resident with a developmental disability upon initial entry of DD foster services or when a DD service rate needs to be reassessed.

The SNAP tool consists of a base rate and additional identified supports. Appendix A provides the DD rates.

- (b) Oregon Health Authority (OHA). Admissions to Adult Foster Homes are governed by OAR 309-040 and OAR 410-173.

OHA has adopted the Level of Care Utilization System (LOCUS) and the Level of Service Inventory (LSI) for Adult Foster Care. The LSI shall be used to support and describe the type and intensity of services required to care for the individual. The LSI shall be used by OHA to assign a service payment as shown in Appendix B. The LOCUS provides additional information regarding the individual's needs and required services and supports to be documented in the person-centered service plan. Should the LOCUS identify a level of care other than AFH, that will not impact the rate paid to the Provider.

To support timely authorization and re-authorization of service authorization requests, the following standards shall be followed:

- 1) Providers shall submit documentation as required, including;
 - a) A completed prior authorization cover sheet as provided by OHA or its designee;
 - b) A document, signed by a licensed healthcare professional, documenting the person for whom services are being requested has a diagnosis of a chronic mental illness;
 - c) A Level of Care Utilization System (LOCUS) assessment;
 - d) A Level of Care Service Inventory (LSI);
 - e) Any additional information supporting the services requested.
 - f) Providers that do not receive documentation in a timely manner shall contact the OHA Designated person to assist them in obtaining documentation.

- g) Clinical documentation submitted by AFH Providers must be completed by a qualified clinician, not by the AFH Provider, and must be unaltered in any form. All documentation regardless of date shall reflect the current needs of the individual.
- 2) Any assessments, LOCUS and LSI submitted for the purpose of supporting authorization or re-authorization must have been completed and dated within one (1) year of the proposed date of admission or re-authorization. All documentation regardless of date shall reflect the current needs of the individual.
 - 3) OHA or its designee will accept and process requests for re-authorization up to sixty (60) days prior to expiration of the current authorization.
 - 4) Providers submitting requests electronically shall receive a confirmation from OHA or its designee regarding receipt of the request and confirmation the request is complete as described in 1 (a-e) of this Section.
 - 5) Providers submitting requests by mail, fax or other means shall be responsible for verification of receipt by OHA or its designee.
 - 6) If the request is incomplete or documentation is insufficient to support the request, OHA or its designee will notify the provider within three (3) business days of any specific issues in writing. The provider shall have ten (10) business days to provide additional written documentation. If the documentation is not received within ten (10) business days of receipt of the letter by the provider, the request will be cancelled without further notice to the provider. If a provider does not have access to the required documentation and it is held by a third party with which the State contracts, the Provider will notify OHA and provide a copy of the request, including date, time and who they submitted request to, and OHA who will reach out to the OHA third party directly to request the third party sends the

information to the Provider. The ten (10) business-day timeline does not go into effect until the Provider receives the documentation from the third party.

- 7) Within ten (10) calendar days of receiving the request, OHA or its designee will make an authorization or re-authorization decision. For Medicaid recipients, OHA or its designee will update MMIS accordingly. An authorization decision means that the prior authorization request has been reviewed and either approved or denied by OHA. For Medicaid recipients an authorization decision also means that a service authorization has been entered into MMIS.

Once Authorization or re-authorization has been approved payment will not be withheld.

- 8) Providers shall receive a written Service Authorization Notice within ten (10) business days of a completed authorization decision. For Medicaid recipients, notice of prior authorization decisions will be in the form of the automated authorization notification letter generated by MMIS. The authorization notification will be sent to the provider at the address of record submitted when the provider enrolled as a Medicaid provider.

Aging and People with Disabilities (APD). The CAPS assessment tool will be used for each person eligible through the APD delivery system. The rate will be paid based on the assessed need of the Individual. The rate is comprised of a base rate, add-ons and exceptions, if applicable. Appendix C provides the APD rate chart.

- (c) For APD Only: The term “base rate” means the payment amount due for providing basic services to the Individual when the assessment does not indicate the need for Add-ons or Exception payments. Add-ons means payment amounts due for providing specific additional services to clients based on the individual’s assessed needs in accordance with the respective assessment tool. For APD, “exceptions” means additional payments for needs not included in the base rate or add-ons that

require additional care and staff to meet the needs of the individual. Questions about whether or not an activity is included in the base rate should be directed to the local office first and, if not resolved, through the AFH Provider Complaint Resolution Process.

- (d) For the DD assessment tool, the term “base rate” is inclusive of the first forty-seven (47) hours per month of assessed support and is the minimum rate for Individuals whose specific care needs are assessed to require less than forty-eight (48) hours per month.
- (e) In the event an assessment tool is modified, which impacts the way a rate is determined, DHS/OHA shall provide the Union with an electronic version of the revised tool with written identification of the specific modifications.
- (f) Providers shall be allowed to provide documentation for an individual’s assessment, including but not limited to person-centered service plan documentation, Incident Reports, Personal Care Plans, Behavioral Support Plans, staffing schedules medical records, treatment plans or records, and doctor’s orders. Assessments will not be completed until the Provider has the opportunity to provide appropriate documentation. Documentation provided by the Provider shall be considered in the assessment. Documentation must be provided no later than ten (10) business days after the individual’s Assessment date.
- (g) If an individual does not want a Provider to attend an assessment, the Provider will have an opportunity to submit both verbal and written information about the individual to inform the assessor completing the assessment. Providers will not be required to sign a copy of the assessment or Budget Summary. The Resident’s Care Plan/ISP will be adjusted to reflect any service need changes identified in a new assessment.
- (h) APD/DD Providers will be mailed or emailed a copy of assessment documents and rate tool summaries including, but not limited to the APD Service Plan or DD

Support Needs Summary no later than ten (10) business days after the assessment is finalized.

- (i) For OHA AFH Providers a copy of the Individual's Mental Health Assessment and the Individual's LOCUS and LSI including the total and composite scores for each tool shall be given at the time of the assessment.
- (j) For DD Individuals: Payments for Individuals in the DD Program residing in an AFH that is licensed by APD or OHA, will be based on the SNAP Tool.
- (k) For APD Individuals: At the discretion of the Department, payments for Individuals in the APD Program residing in an AFH that is licensed by DD or OHA, will be based on the assessment best meeting the unique needs, but no lower than those established in the APD Service Rate Chart.
- (l) For OHA Individuals: Payments for Individuals in the OHA Program residing in an DHS Licensed AFHs, will be based on the OHA assessment tool.
- (m) For all AFH providers; Full payment is made for each day of service as defined by rule or law.

9.3 RESIDENT SERVICE RATES AND SUPPORT NEEDS

DHS/OHA shall provide in writing:

- Each Individual's service rate that shows the amounts for the base rate, supports/add-ons and exceptions where applicable, and
- Each Individual's service and support needs.
- Upon completion of an assessment and approval authorizing an add-on or exception, payment for the add-on or exception will be paid retroactive to the assessment supporting the need for the add-on or exception if an

assessment is needed or to the date the request is approved for situations which do not require an assessment.

The information above shall be available prior to an Individual's admission into an AFH home unless the AFH chooses to accept the individual without that information in an emergency situation.

9.4 SERVICE PAYMENTS FOR AFH SERVING INDIVIDUALS IN THE BEHAVIORAL HEALTH SYSTEM

- (a) Timely Payments. OHA Providers serving Medicaid eligible individuals in the behavioral health system must submit service payment requests through the MMIS Web Portal or using the CMS 1500. Such requests properly submitted by noon on Friday will be processed each Friday, excluding holidays, and will be sent to the Provider's financial institution through Electronic Transfer (EFT) within three (3) business days. If a holiday occurs on Friday, the payment claims will be processed within a day earlier or later. All Providers will be notified of this alternative payment schedule. Providers who request to have their checks mailed to them will receive the check within seven (7) to ten (10) business days following proper submission.
- (b) Notification of Errors. Providers' claims that are not properly submitted through the Web Portal will receive immediate feedback from the system. Providers may then correct the error(s) in "real time." A Provider who submits a CMS 1500 will receive a Remittance Advice (RA) by mail within seven (7) to ten (10) business days following submission.

For Providers serving Individuals enrolled in Medicaid managed care, Providers shall submit claims to the Individuals assigned coordinated care organization using the billing and claiming procedures established by the coordinated care organization.

OHA shall immediately notify the Providers of any expected changes in client income, such as adjustments to SSI payments.

9.5 SERVICE PAYMENTS FOR AFH PROVIDERS

- (a) For APD only: Payments for AFH Providers paid through the DHS Community Based Care (CBC) payment system will be processed within two (2) working days of the first of the month for services with prior authorization that have cleared eligibility. Payment is made for services provided in the previous month.
- (b) For OHA Only: See Letter of Agreement – Service Payments for OHA Non-Medicaid Consumers
- (c) For DD only: Payment for AFH Providers is paid through the eXPRS payment system, Providers will be required to submit a claim via the web-based system for the days the service was provided and the individual was in the home overnight. Payments for approved claims will be processed within two (2) working days.

9.6 PAYMENTS FOR DAYS OF SERVICE

When an individual does not sleep in the Adult Foster Home overnight, the Adult Foster Home (AFH) Provider may still file a claim for that day when one (1) of the following is true, can be documented and the individual intends to return to the home: Within an accumulated period of at least eight (8) hours in a twenty-four (24) hour period (12:00AM – 11:59P), the Provider was responsible for the primary care, support, safety and wellbeing of a the individual including, but not limited to the following: Providing intermittent physical support or care; Providing stand-by support with the ability to respond in person within the person centered plan team agreed upon response times as outlined in the most current person centered plan. Being responsible to communicate reciprocally within the response times agreed upon by the person centered plan team and based on an individual's identified support issue and documented within the most current person centered plan. The AFH Provider is not eligible to file a claim for the day (12:00AM – 11:59PM) when the individual is: - admitted to a hospital, - admitted to a nursing facility, - outside the United States – held in detention or jail, AFH Providers are not required to remain with an individual to provide unpaid supports once an individual is “admitted” to the hospital or nursing facility. All services not directly provided by the AFH Provider or

the care giver, must be billed by the rendering AFH Provider. Examples of this are behavioral consultants, nursing Providers and employment Providers.

The above paragraph does not apply when an individual is transitioned to another care setting that is being paid for those services.

9.7 TRAINING AND MATERIALS

- (a) Providers enrolled with the OHA to bill for services using MMIS have access to training and technical support to ensure that Providers can perform the following: request prior authorization, submit claims, adjust claims and reading remittance advice for payments received. OHA shall notify Providers of date, time and locations for training, in accordance with Article 6.2.
- (b) Providers of Adult Foster Care services will have the same access to training and information as all OHA enrolled service Providers using MMIS.
- (c) Providers of DD Adult Foster Care services will have access to training materials (written and video) and information using eXPRS.

9.8 NOTIFICATION OF PAYMENT SYSTEM CHANGES

Whenever changes are made to the payment processing systems, all affected Providers will be notified of and provided to or have access to training materials on changes at least thirty (30) days prior to implementation.

9.9 CHANGES TO SERVICE PLAN AND PAYMENTS

- (a) Providers shall be issued documentation of the specific services they are expected to provide.
- (b) Providers shall be given written notice of the amount they will be paid for said service(s) and may include explanation of the base rates, add-on/supports and

exceptions where applicable. Written notice will be given for the following within seven (7) to ten (10) days of a completed reassessment:

- 1) Change in Service Plan
 - 2) Changes in Service Payment(s)
- (c) Rates that stay the same or increase will be effective on the date of the completed assessment.
- (d) Rate amounts that decrease will take effect no sooner than ten (10) business days after date of the notification is sent to the Provider.
- (e) Reassessments. Upon receipt of a proper request for reassessment due to a change in condition of the Individual, the date of the reassessment will be scheduled within ten (10) business days in order to occur within the required forty-five (45) day period. If a Resident's reassessment (SNAP, CAPS or LSI) result in different service needs, the applicable care plan/ISP will be adjusted accordingly. If a resident's support needs increase after a hospitalization, a reassessment shall be conducted within thirty (30) days after their discharge back to AFH. Any increase to service payments resulting from a reassessment will become effective upon the actual date of the reassessment.

It is recognized that some client conditions are of greater immediacy of reassessment than others and are a priority for scheduling a reassessment. Any time there may be a significant change in an individual's support needs, the case management entity can determine, based on information provided in a request for a reassessment, that a more urgent assessment may be needed due to immediate risk of harm to the individual or others resulting from the change in support needs. When such determination is made, the date of the reassessment will be scheduled within five (5) business days in order to occur within twenty-one (21) calendar days.

Request means:

- 1) the request is in writing, and
- 2) the reasons for the request are stated based on the change in individual conditions.

However, if the change in conditions is not based on the Individual's clinical, medical, physical or behavioral health needs, the request will not meet criteria for a reassessment. The Provider will be notified that the consumer does not meet the criteria for reassessment within seven (7) business days.

9.10 ASSESSMENT REVIEWS

- (a) **Assessment Review.** If the Provider believes an error was made in notation of the assessment tool, the Provider can request the assessor or case manager to review and verify the area of concern. If the Provider's concern is not resolved, the Provider must submit a request in writing to the DHS/OHA designated complaint contact within thirty (30) days of the completed assessment. DHS/OHA will respond within two (2) weeks of the written request. Contact information will be posted on the appropriate provider websites. At the time of licensing and relicensing, the State will inform Adult Foster Home Providers of the website address with the DHS/OHA designated complaint contact.
- (b) If the Provider feels the issue is not resolved, they may initiate the complaint process within thirty (30) days of the DHS/OHA response.
- (c) Rate Change Explanation. If an Individual's rate increases or decreases based on change of need as identified in a reassessment, the Provider can ask for an explanation of the change(s) made by the reassessment. The request must be made in writing to the DHS/OHA designated contact within thirty (30) days of the

completed assessment. DHS/OHA will respond within two (2) weeks of the written request.

9.11 NOTIFICATION TO PROVIDERS

Agency personnel shall notify the relevant Provider when they become aware that an established resident is not returning to the Provider's home.

9.12 OVERPAYMENTS

- (a) Overpayments resulting from Employer or Provider error shall be recouped according to applicable Oregon Administrative Rules, which do allow a Provider to negotiate a payment schedule between the Provider and DHS/OHA; in general, repayment will occur within six (6) months, but if the amount would be larger than twenty percent (20%) of the Provider's monthly service payments, payment plans may be as long as eighteen (18) months. If the Provider discontinues his/her work as an AFH Provider before the overpayment has been fully recovered, the remaining amount may be deducted from the Provider's final payment.
- (b) The Provider shall receive a written notification of the overpayment prior to any recovery efforts. The notification will include information about the ability to negotiate a payment schedule within ten (10) business days between the Provider and DHS/OHA.
- (c) A Provider who disagrees with the determination that an overpayment has occurred, may grieve the determination through the grievance procedure.

9.13 OREGON MINIMUM WAGE COMPLIANCE

If during the term of this Agreement, the Oregon minimum wage increases to exceed any AFH rates driven by staffing costs, including but not limited to 1:1 rates, 2:1 rates and exception based rates, then the Parties shall commence bargaining. The Parties agree that these negotiations shall be limited to increases to Provider rates to cover increased

staffing costs due to the minimum wage increase. The Parties agree to commence bargaining within thirty (30) days of the passage of any legislation or ballot initiative. Either Party may invoke Mediation after bargaining has commenced for at least sixty (60) days. Thereafter, the timelines and procedures set out in ORS 243.712 and 243.742 shall apply unless the Parties mutually agree in writing, otherwise.

9.14 COST OF LIVING ADJUSTMENT

In recognition of the risks and sacrifices undergone by Adult Foster Home Providers during the COVID-19 Pandemic, the Parties agree to grant the following increase to service payments: Effective July 1, 2021, the service payments of all Providers in Appendixes A, B, and C shall be increased by five percent (5%).

Effective April 1, 2022, the service payments of all Providers in Appendixes A, B, and C shall be increased by two point three percent (2.3%).

The COLAS for all Provider types shall be added to the previous 2019-2020 rates.

Exceptional Rates will be granted when a resident and Provider meets the requirements found in OAR 411-027 or the Resident requires nighttime services that prevent a Provider from getting at least five (5) hours uninterrupted sleep per night.

9.15 RESIDENT MANAGER SCHEDULES

In order to be in compliance with FLSA and overtime regulations, Providers may apply for and be granted variances to the specific day per week Resident Manager requirement.

9.16 ADMINISTRATIVE RULES

Providers will only be required to comply with the OARs under which they are licensed, except as outlined below, when admitting a Resident from another licensing group.

Providers agree to comply with the applicable OARs when admitting a client from a

program other than the program under which the provider is licensed or certified. The Provider will not be expected to comply with additional OARs unless it has been specified in the individual's care plan and funded accordingly. The Department will provide the standardized list of applicable rules upon admitting a client from a program other than the program under which the provider is licensed or certified.

REV: 2017,2019, 2021

ARTICLE 10 – PRE-PLACEMENT PLANNING

10.1 PRE-ADMISSION PROCESS

Prior to any admission, the Adult Foster Home Provider and the local case manager/office should work cooperatively to ensure that an appropriate placement occurs.

10.2 PLACEMENT IN AN APD, OHA and DD ADULT FOSTER HOME

Prior to approving the placement of a Medicaid resident for admission to an Adult Foster Home, the local case manager, Resident Specialist, or other State representative shall provide all relevant information, in accordance with administrative rules and federal regulations relevant to the care of the individual, to the Adult Foster Home Provider so the provider can make informed decisions about placement in the provider's home. At minimum, when such information will include the following when known to the case manager or contained in the case file:

1. any history of prior placements
2. Income: amount of any offset
3. Medical: a medical history including current medical insurance, prescription drug coverage, dental coverage, current medical, dental, mental health prescribers, any current or past medical and mental health, addictions diagnoses, current physical, psychological exam/assessment, treatment plan, and current medications, and all current physician's orders. Any protected health information will be provided in a manner that assures HIPAA compliance.
4. Support Needs: a summary of support needs for activities of daily living, any recent care plans, any recent behavioral plans, any transportation eligibility, current work programs available and any known behavioral and/or risk factors, including but not limited to criminal history contained in the case file or related to service provided by AFH.

10.3 ADULT FOSTER HOME PROVIDER RESPONSIBILITIES

Notwithstanding information listed in Section 2 of this Article, the Adult Foster Care Provider continues to be responsible for the following prior to any private or public placement into the home: conducting and documenting their own screening and assessment of the resident's needs in accordance with the rules to determine the Provider's capability to support the individual; obtaining the approval of the individual's case manager or CDDP prior to any admission; and to not accept any placement until all necessary information is available to provide care. The provider will retain the right to deny admission of any person for any reason not specially prohibited by rule or law.

10.4 PRIVATE PLACEMENTS

Placements made privately by families, through private placement agencies, directly by hospitals or any other agency without the involvement of a case manager, or by brokerages or Community Developmental Disabilities Program (CDDP) for respite services do not apply to this Article.

REV: 2019, 2021

ARTICLE 11 – UNION REPRESENTATION

11.1 RIGHT TO UNION REPRESENTATION

DHS/OHA shall not preclude the Provider from having a Union representative present (either in-person or by telephone) to provide assistance and support to the Provider during an abuse or neglect investigation, licensing visit, or informal conference between the Provider and licensing authority of the State. A licensing visit includes an annual licensing inspection or a monitoring visit.

11.2. CONTESTED CASE HEARINGS

Pursuant to State law a Provider may represent him or herself in a contested case, otherwise he/she must be represented by an attorney.

11.3 INVESTIGATION PROCESSES

DHS/OHA (or designee) will notify a Provider of any investigation opened against the Provider, License or Home, as legally required. DHS/OHA will inform the Provider of the nature of the investigation, including the OARs potentially violated and the general rights and responsibilities of the Provider as legally required. DHS/OHA will allow Providers an opportunity to offer additional information or evidence, as legally required. The outcome of the investigation will not be finalized until such information has been reviewed. DHS/OHA will make reasonable efforts to accommodate a Provider's request to include a Union representative during the activities outlined in Section 1 of this Article. Such requests will not unreasonably delay those activities nor will a request for Union representation result in the re-scheduling of a licensing or investigatory visit that would otherwise be conducted without advance notice. The Union representative shall not be allowed to interfere with the ability of the licensing authority or its designee to conduct or complete the activities outlined above and will not be allowed to interfere with the health and safety of residents in the adult foster home. A Union representative will not be allowed to participate in witness interviews.

11.4 CONFIDENTIALITY

It is the responsibility of Providers to follow HIPAA Standards at all times. A Union representative will be expected to sign a confidentiality agreement prior to having access to or receiving any confidential information. Any Union representative present during any interaction between DHS/OHA or its designee and a Provider as set forth above, and who had access to client-specific protected health information during the course of that interaction, shall keep such information confidential and shall not use or disclose such confidential information for any purpose other than for the provision of assistance and support to the Provider. Union representatives will be bound by all relevant statutes governing confidentiality of health care information, including but not limited to statutes applying to drug and alcohol treatment.

Due to confidentiality requirements, names of all complainants, reported victims, witnesses and perpetrators shall be omitted for purposes of Union representations.

Abbreviations used (written and verbal):

C or CC	Complainant
RV	Reported Victim
W or Wit	Witness
RP	Reported Perpetrator

11.5 GRIEVANCE DEFINITION

Grievances for alleged violations of this Article shall be limited to the denial of rights provided by this Article.

11.6 INVESTIGATION STATUS REQUESTS

Providers or Union Stewards can request a status update from the local office or OTIS regarding any active investigation and will receive a response within fourteen (14) days of that request. If the Provider or Union Steward does not receive a response they may

go through the AFH Complaint Resolution Process for assistance. This Section is not considered grievable under this CBA.

11.7 REVIEW OF CASE FILES

Provider will have the ability to review all case files held at the county, state or any contractor designated by state or county that involves their adult foster home and the Provider shall have an opportunity to respond to any changes in their record.

11.8 PROTECTIVE SERVICE INVESTIGATIONS RESULTING IN SUBSTANTIATED FINDINGS

Investigations of protective services will investigate allegations of abuse and substantiations shall be apportioned to the individual(s) who committed the abuse. Persons with substantiated findings may have the opportunity to appeal the decision or request a petition for reconsideration pursuant to the DHS/OHA/OTIS Administrative Rule. The apportionment of substantiation in no way diminishes the Departments' ability or authority to issue a civil penalty as appropriate. DD investigations do not include apportionment.

REV: 2017,2019,2021

ARTICLE 12 - AFH PROVIDER COMPLAINT RESOLUTION PROCESS

12.1 COMPLAINT PROCESS PROCEDURE

It is the intent of DHS to have an efficient and effective resolution process for complaints from represented Adult Foster Home Providers about complaints not covered by the Collective Bargaining Agreement.

Provider concerns or complaints may include such things as licenser or investigator behavior, timeliness of re-assessment or response to a reported change of condition, timely provision of client-specific information, or instances where the Provider believes DHS did not follow rule. This complaint resolution process will not supplant other due process rights specified in applicable Oregon Administrative Rules.

To this end, the Parties agree to the following:

12.2 COMPLAINT PROCESS STAFFING

A staff person, or back-up, will be designated as the single point of contact to receive, track and respond to AFH Provider complaints. This staff person will coordinate with SEIU and all three adult foster home programs (APD, DD, AMH) and local offices, as the single point of contact to receive, track and respond to AFH Provider complaints. A written response will be sent through email, fax or postal letter to the Provider acknowledging the complaint has been received and the expected timeline for an initial response, when the Provider submits contact information with the complaint.

12.3 DATA TRACKING

The designated staff persons will use a data base or electronic spreadsheet to track AFH Provider complaints. Non-confidential information contained within the complaint training database will be transmitted to the Union on a quarterly basis and in electronic format.

12.4 ANNOUNCEMENTS TO PROVIDERS

DHS/OHA will announce to Providers at the time of initial Medicaid Enrollment and annually thereafter, its process for Providers to contact the staff designee with complaints, (i.e., designated e-mail address). The announcement will include the following information:

- (a) If the Provider is represented, the Provider may request Union representation through the SEIU Member Resource Center (MRC).
- (b) Providers should first attempt resolution with their local office.
- (c) This complaint resolution process is intended for use by Providers only.

12.5 LOCAL RESOLUTION

This complaint resolution process should not supplant Provider contact with a local office to reach a resolution. After that initial setup, Providers, with support from the SEIU MRC if requested, may submit concerns through the Complaint Resolution process.

12.6 COMPLAINT SUBMISSION PROCESS

SEIU and AFH Providers agree to submit concerns and complaints to DHS/OHA in writing using a designated form. Complaints completed using the designated form may then be submitted through the designated email address, fax number or postal address.

12.7 QUARTERLY ISSUES MEETING

The Parties will meet on a quarterly basis to review the Complaint Resolution Process for efficiency, effectiveness, and to identify trends. The Agencies will have one (1) representative from each of the three (3) program areas on the Committee and the Union shall have an equal number of members. If issues arise from these quarterly reviews, equal numbers of representatives from DHS/OHA and SEIU may meet to resolve those issues.

ARTICLE 13 – NO RETALIATION

13.1 PROTECTED UNION ACTIVITIES

The State agrees that no Provider, on account of membership or non-membership, shall be retaliated against, intimidated, restrained or coerced in or on account of the exercise of rights granted by the Collective Bargaining Agreement or in protected activities on behalf of the Union.

13.2 LEGAL AND CONTRACTUAL RIGHTS

No agent of the State shall engage in any act of retaliation against any Provider for seeking to exercise any legal or contractual right or seeking to fulfill or comply with any legal or contractual obligation.

13.3 CLAIMS PROCESS

The State and the Union agree that behaviors that contribute to a hostile, humiliating, or intimidating environment are unacceptable and shall not be tolerated.

Providers who believe they are subject to such behavior by any agent of the State should first attempt resolution through the AFH Provider Complaint Resolution Process. The Provider should initiate the process as soon as possible, but no later than ninety (90) days from the occurrence of any incident.

If resolution is not reached through the Complaint Process within thirty (30) days, the Provider may report their concerns directly to the OHA/DHS Director or designee. The OHA/DHS Director or designee shall provide a written response within thirty (30) days. No Provider shall be subject to retaliation for filing a complaint, giving a statement or otherwise participating in the administration of this process.

The written response/decision of the DHS/OHA Director under this Section is not grievable under this Agreement.

ARTICLE 14 – INSPECTION VISITS

Inspections by DHS/OHA and/or their contractors, shall be conducted as follows:

- (a) Inspectors are required to show valid department ID.
- (b) Inspections may be conducted with or without an appointment except if advance notice may obstruct or seriously diminish the effectiveness of the inspection or enforcement of rules. This provision is not intended to conflict with the Oregon Administrative Rules for each program and where there is a conflict the appropriate OAR will prevail.
- (c) In order to ensure consumers have the attentive care they need, DHS/OHA and/or their contractors shall consider, when determining whether or not to schedule a renewal visit by appointment at a date and time agreeable to all parties, whether or not the visit might require the licensee or their staff to divert their attention from a consumer to the inspector (e.g. the inspection of provider files and paperwork). This provision is designed to acknowledge and respect the provider, the sanctity of the home and the range of support needs for residents who rely on staff for their support and care.

NEW: 2019

ARTICLE 15 – SUBCONTRACTORS

The State shall provide, to all subcontractors and third parties to which it has delegated responsibilities related to the licensing and supervision of Adult Foster Homes, a copy of this Collective Bargaining Agreement and shall train the responsible parties on its contents. The State shall require all such subcontractors and third parties shall be responsible for adhering to all provisions in this Collective Bargaining Agreement, and the State shall not enter into any contract with such entities that contradicts this Collective Bargaining Agreement in whole or in part.

NEW: 2021

ARTICLE 16 - LABOR MANAGEMENT COMMITTEE

16.1 PURPOSE AND SCOPE

To facilitate communication between the Parties, a joint Labor Management Committee shall be established. The Committee shall take steps to ensure consistency with the Collective Bargaining Agreement. The Committee shall be on a meet-and-confer basis only and shall not be construed as having the authority nor entitlement to negotiate.

The Committees shall have no power to contravene any provision of the Collective Bargaining Agreement, nor to enter into any agreements binding on the Parties to this Agreement or resolve issues or disputes surrounding the implementation of the Contract. Matters which may require a Letter of Agreement shall not be implemented until a Letter of Agreement has been signed by the DHS Labor Representative and the Executive Director of the SEIU Local 503, OPEU.

No discussion or review of any matter by the committees shall forfeit or affect the time frames related to the grievance procedure. Matters that should be resolved through the grievance procedure shall be handled pursuant to ARTICLE 7 –GRIEVANCE PROCEDURE. At the conclusion of each fiscal year, the Parties shall discuss the concept of Labor-Management Committee and whether it should be modified, continued, or discontinued.

16.2 COMPOSITION

The Committee shall be composed of five (5) AFH members appointed by the Union and five (5) members representing the State including one (1) representative from each of the three (3) program areas. The State and the Union may mutually agree to establish joint subcommittees.

16.3 MEETING SCHEDULE

The Committee shall meet when necessary, but not more than once each calendar quarter, unless mutually agreed otherwise.

NEW: 2021

ARTICLE 17 - STANDARDIZE CRIMINAL BACKGROUND CHECK PROCESS FOR ALL AFH PROVIDERS

Purpose: To ensure a criminal background check system that is standardized and efficient, by enabling Providers the ability to conduct Oregon Criminal History and Abuse Records Data System (ORCHARDS) checks and provide preliminary approval in a prompt manner. Providers are then able to hire and train and retain caregivers. A Subject Individual (SI) who has been hired on a preliminary basis shall be actively supervised at all times by an individual who has been approved without restrictions. Active supervision, whether inside or outside of the facility, means the preliminary caregiver must be within direct line of sight and hearing of an individual approved without restrictions at all times.

The State shall maintain a standardized criminal background check system for all Providers statewide. This system shall do the following:

1. Grant all Providers, or their designees, who meet the requirements of, and who are approved to be, a DHS Qualified Entity Designee: and who complete all applicable requirements under the Department Background Check Unit, including record retention and confidentiality, access to conduct criminal background checks for potential employees.
2. APD-licensed Providers may use the Long Term Care Registry component of ORCHARDS for lists of immediately hireable employees. If statute changes to include DD or AMH providers in the Long Term Care Registry, the Parties agree to modify this Article accordingly.
3. Upon ratification of this Agreement, the State shall modify any existing OARs to allow for the preliminary approval of SIs as outlined above.
4. The State will provide all Adult Foster Home providers information on how to sign up for ORCHARDS on an annual basis.

NEW: 2021

ARTICLE 18 – SPECIFIC NEEDS CONTRACTS

Any amendments to Specific Needs Contracts, including those required for legal and compliance purposes, will be communicated to the Union and to the affected provider no later than ninety (90) days from the intended implementation. Upon a demand to bargain, the Parties will meet to discuss the impact of those changes.

All Specific Needs contracts will explicitly acknowledge that the rate of pay is determined by the SEIU Local 503 Adult Foster Home Collective Bargaining Agreement.

LETTER OF AGREEMENT - JOINT CONTRACT TRAINING

The Parties have a mutual interest to ensure that key staff and partners with AFH program responsibility share mutual knowledge and perspectives on the terms of the Collective Bargaining Agreement.

To that end, after the Collective Bargaining Agreement is ratified, the intent of the Parties is to collaborate to present training to the key staff and partners.

LETTER OF AGREEMENT – BACK UP PROVIDER AGREEMENTS

This Letter of Agreement (LOA) is entered into between the Department of Administrative Services (DAS) on behalf of the Oregon Health Authority (OHA), (the “Agency”) and SEIU Local 503 (the “Union”) and collectively (the “Parties”).

The purpose of this Agreement is to acknowledge that the current ruleset for providers within the APD Program has called for a back-up provider relationship since 2013, when the rule was originally placed. This rule has not always met the intended aim and may present an undue burden on providers and those they seek to have a back-up provider relationship with.

To better support provider needs during an emergency, the Department agrees to review and updates this ruleset when rules are open after the 2021 legislative session ending June 27, 2021. The proposed updates will be available for discussion and feedback during the APD 2021 rules advisory committee meetings and will be reflective of provider needs during an emergency with an understanding of the importance of maintaining resident safety and health during extreme circumstances. The State will inform the Union of the dates that the APD 2021 rules advisory committee meetings will take place as soon as the dates and times are known,

This Agreement shall expire on June 30, 2023, unless extended by mutual agreement.

LETTER OF AGREEMENT – SPECIFIC NEEDS CONTRACTS

This Letter of Agreement (LOA) is entered into between the Department of Administrative Services (DAS) on behalf of the Oregon Department of Human Services, Aging and People with Disabilities, (the “Agency”) and SEIU Local 503 (the “Union”) and collectively (the “Parties”).

The purpose of this Agreement is to develop a joint workgroup that will focus on the expectations of Specific Needs contracts, how providers can meet those contract requirements as defined in the statement of work, and recommend certain parameters for and terms to be included in Specific Needs Contracts.

The Parties agree to the following:

1. The workgroup shall consist of no more than four (4) Union representatives and four (4) Agency representatives.
2. The workgroup will have two co-chairs; one representing the State and one representing SEIU 503 who will be responsible for convening the meetings and creating the agendas.
3. The workgroup will identify improvements in the process for reviewing contract amendments and identify processes that will help providers understand the requirements in these contracts.
4. The workgroup will also develop tools to help providers be successful in complying with the provisions of their specific needs contracts.
5. The State will inform the workgroup which State Agencies are responsible for each part of the Specific Needs contracts.
6. The workgroup will jointly create recommendations for improvements to specific needs contracts that meet the contract requirements. The workgroup will complete these recommendations and submit them to APD/ODHS (the “agency”) no later than January 1, 2023.
7. The workgroup will work collaboratively to develop a manual that helps the contractors effectively manage the contract expectations.

8. The workgroup shall meet at least once every quarter.
 - a. If allowed by law and OAR, all Specific Needs contracts will explicitly acknowledge that the rate of pay is negotiated with the SEIU Local 503 Adult Foster Home Collective Bargaining Agreement.

If both Parties agree that the committee has completed the work outlined in this Agreement, this agreement shall expire on June 30, 2023.

**LETTER OF AGREEMENT - IMPROVEMENTS TO LSI MANUAL FOR INDIVIDUALS
SERVED UNDER APPENDIX B**

This Letter of Agreement (LOA) is entered into between the Department of Administrative Services (DAS) on behalf of the Oregon Department of Human Services, Oregon Health Authority, (the “Agency”) and SEIU Local 503 (the “Union”) and collectively (the “Parties”).

The purpose of this agreement is to provide clarity of the LSI assessment tool for determinations for the Behavioral Health Adult Foster Home Base Rate (Appendix B).

The Parties hereby agree to the following:

- 1) The State will revise the LSI manual to add clarity as to how behavioral health supports can be included in the listed items for non-add-ons and add-ons.
- 2) Revisions will be completed by December 31, 2021.
- 3) The new LSI manual will be effective as of January 1, 2022.
- 4) Revisions to the LSI manual will not result in a reduction of rates for any provider.

This Letter of Understanding will expire on June 30, 2023.

**LETTER OF AGREEMENT – SERVICE PAYMENTS FOR OHA NON-MEDICAID
CONSUMERS**

This Letter of Agreement (LOA) is entered into between the Department of Administrative Services (DAS) on behalf of the Oregon Department of Human Services, Oregon Health Authority, (the “Agency”) and SEIU Local 503 (the “Union”) and collectively (the “Parties”).

The purpose of this agreement is to develop a solution for timely payments for consumers who are not Medicaid eligible. The Parties hereby agree to the following:

- 1) The State will develop a process for non-Medicaid payments to Adult Foster Homes on a timely basis.
- 2) The State will partner with the Union to communicate the changes to the affected Providers.
- 3) The State will determine an appropriate implementation plan and timeline and will share with the Union by July 1, 2022.

LETTER OF AGREEMENT – COVID-19 HAZARD BONUS – ADULT FOSTER HOMES

This Letter of Agreement (LOA) is entered into between the Department of Administrative Services (DAS), the Oregon Department of Human Services (DHS) and the Oregon Health Authority (OHA), (the “State”) and SEIU Local 503 (the “Union”) and collectively (the “Parties”)

In recognition of the Providers who were asked to take greater personal risks during the COVID-19 pandemic by being recruited to work in person, the Parties agree to the following:

Providers who worked during the height of the pandemic, between March 2020 and February 28, 2021, shall receive a one-time payment based on the following criteria:

- All Adult Foster Home Providers serving Medicaid consumers will receive a one-time payment of one thousand dollars (\$1,000) for each resident served from March 1, 2020 through February 28, 2021 contingent upon CMS approval.
- Providers must have an active provider number at the time of the payment on December 1, 2021.

STATEMENT OF INTENT - TRAINING

Section 1. Training Initiative.

- A. It is the intent of the Parties to the Collective Bargaining Agreement to continue the Adult Foster Home (AFH) Training Committee with goals and responsibilities outlined below. The Training Committee shall continue a subcommittee for OHA with a minimum of three (3) OHA providers to address specific areas of concern. The training committee may appoint additional subcommittees for other specific program areas. The Training Committee may disband subcommittees by consensus decision. The AFH Training Committee shall consist of the following members:
1. A minimum of five (5), and up to ten (10) with mutual agreement, representatives from DHS/OHA Central and field offices, who bring specific program knowledge and expertise related to the services provided by Foster Care Providers covered under this Collective Bargaining Agreement (CBA).
 2. A minimum of five (5), and up to ten (10) with mutual agreement, representatives from SEIU/AFH.
 3. Two (2) representatives from other community-based care Provider groups, e.g. ALF's, RCF's, group homes, homecare, residential treatment facilities, or private pay adult foster homes, not already represented by SEIU/AFH.
- B. Based on a shared understanding that quality training enhances skills and improves services provided to residents, the Committee shall have the following broad training goals:
1. Continue to improve and streamline the process for approval of AFH training and/or continuing education unit requirements, including identifying categories of qualified community partners pre-approved to provide training.

2. Continue to explore opportunities to work with agencies and community partners to provide more comprehensive training and alternative methods to deliver training to AFH Providers.
3. Continue to explore methods to make training opportunities to AFH Providers more accessible, such as on-line course study, CD/video/audio curriculum and in-classroom settings.
4. Communicate approved training opportunities through multiple methods, including an identified DHS/OHA website.
5. Continue to invite other appropriate partners, as necessary or as requested by the committee members, to attend the meeting(s) to provide their expertise on training-related topics/issues.
6. Explore free and low-cost on-line training options that meet mandated annual continuing education (training) requirements.

Within twelve (12) months of implementation of this Agreement the Committee shall work to achieve the following goals and outcomes:

- (a) Maintain the minimum number of required hours/courses available for free on-line (twelve (12) hours for APD, DD and twelve (12) hours for OHA (including the eight (8) required areas). Some courses may meet the requirements for all three (3) program areas.
- (b) Evaluate the options for converting current non-digital training to an on-line format. The Agency will convert the current Agency self-study modules to an on-line format within this twelve (12) month period. The Agency will review and update the self-study content as needed during this process.

- (c) Discuss appropriate disclaimers to post on the DHS/OHA website to ensure Providers understand that repeat classes may not meet requirements and that the posted 'approved' classes meet the minimum requirements only and may not reflect Agency endorsement.
 - (d) Discuss and make recommendations regarding the frequency in which certain courses may be repeated.
 - (e) Develop a plan to keep at least the minimum amount (as referenced in 6(a) above) of free on-line training opportunities posted on the DHS/OHA website.
 - (f) Will condenser developing online or self-study training related to the most common licensing deficiencies.
- C. The results of the committee's work, including recommendations, shall be sent to the Department of Human Services (DHS) Administrators and Oregon Health Authority Administrators (OHA). If DHS or OHA decides to implement any portion of the committee's recommendations, it will strive to give prior notice to the committee members.
- D. DHS/OHA, in coordination with the Training Committee, shall complete the following:
 - 1. Develop criteria and implement a form for Providers to record training that does not need prior approval;
 - 2. DHS/OHA will keep the Training Committee informed on its progress to implement the Training program.
- E. DHS/OHA and SEIU Local 503 may jointly participate in developing grant opportunities, including any funds available through federal programs.

LETTER OF AGREEMENT - RN DELEGATION

Purpose: To continue efforts from workgroup recommendations from the 2013-2015 Adult Foster Home CBA Statement of Intent: RN Delegation.

1. By January 1st, 2016, the Department will review and update relevant curriculum for the AFH orientations (DD & APD) and include information to State and County staff through a transmittal to include the following:
 - a. Information on options for AFH providers to become Long Term Care Community Nurse.
 - b. Information about wrap around services available when delegated task is needed during off-hours (nights, weekends, holidays). Hospital/Doctor responsibility to set-up plan for meeting needs (Home Health / Agency / Family Member) until delegation available.
 - c. Clarity around options available to the Provider when an Individual's care needs change, resulting in care that exceed the providers licensed ability, and there is not available wrap-around services with appropriate licensure.

2. Nurse delegation services will be billed by the rendering RN Provider unless it is a requirement in the specific needs contract. The State will inform Adult Foster Home Providers, on an annual basis, how the individual and Provider can access RN delegation services.

If a Medicaid resident is hospitalized and the Provider is unable to provide safe care on readmission due to lack of nursing delegation, the Provider shall not be required to readmit the resident until the necessary nursing delegation services are available. The Provider must work with the case management entity on a resolution. This Article does not override the requirements in Oregon Administrative Rules.

LETTER OF UNDERSTANDING – LONG TERM CARE COMMUNITY NURSING PROGRAM

An Adult Foster Home Provider may apply for the Long-term Care Community Nursing Program while still operating as an Adult Foster Home Provider. They are responsible for following all policies, procedures and administrative rules under the Long-term Care Community Nursing program while ensuring compliance with administrative rule, policy and procedures for their respective Adult Foster Home program.

With prior case manager authorization, an Adult Foster Home Provider who is licensed in Oregon as a Registered Nurse (RN) may be paid for Long-term Care Community Nursing services for clients in their own foster home. Prior authorization is based on case management and client determination and an Adult Foster Home Provider is not guaranteed to have authorization for a client residing in their own Adult Foster Home for Long-term Care Community Nursing services. An Adult Foster Home Provider must have a Long-term Care Community Nursing services contract and a separate and distinct Medicaid Provider number from their Adult Foster Home contract and Medicaid Provider number.

Adult Foster Home Providers who are performing duties as a Long-term Community Nurse must assure that the needs of other residents in their home are met up to and including additional staffing.

The State will notify local offices of this policy clarification within sixty (60) days of contract ratification. This only applies to Providers and clients eligible for Long-term Care Community Nursing Services in Aging and People with Disabilities (APD) and Developmental Disabilities (DD) programs.

Adult Foster Home Providers in the Addictions and Mental Health (AMH) programs should work in their Community Mental Health Program (CMHP) or the patient's Primary Care Provider.

APPENDIX A

Rates for Adult Foster Homes Serving Individuals with Developmental Disabilities

All rates, rate rules, and components of the SNAP Tool, except equipment, outlined below shall be adjusted in accordance with the COLA rate provided for in Article 9.13.

A.1 RATE RULES

1. Base Rate is inclusive of the first forty-seven (47) hours per month of assessed support and is the minimum rate for individuals whose specific care needs are assessed to require less than forty-eight (48) hours per month (only “over 18-age residents”):

July 1, 2021 \$935.55

2. Base rate, \$856.00, is the minimum service rate. Base rate includes \$480 for assessed supports and \$376 for ancillary costs. Assessed support in excess of the \$480 is added to the base rate.

3. Total maximum rate (before consideration of 2:1 needs): \$7804.00

July 1, 2018 \$8521.04

July 1, 2021 \$8947.10

April 1, 2022 \$9152.88

4. Additional rate for 2:1 assists:

(a) Effective July 1, 2020: \$14.16/hr for the additional staff for the 2:1 hours approved.

(b) Effective July 1, 2021: adjusted per the COLA percent in Article 9.

Any 2:1 services required in an Individual’s ISP shall be funded in accordance with the hourly rates outlined above and include timesheets verifying 2:1 hours by a caregiver. Timesheets must be available upon request.

	Full Assist	1,065.59	1,118.87	1144.60
	Full Assist Constant/ Aspiration Risk	1,065.59	1,118.87	1144.60
Toileting	Full Assist	354.81	372.55	381.12
Bladder Control	Partial Assist	177.99	186.69	191.19
	Full Assist	710.78	746.32	763.48
Bowel Control	Partial Assist	177.99	186.89	191.19
	Full Assist	710.78	746.32	763.48
Menses	Partial Assist	88.42	92.84	94.98
	Full Assist	177.99	186.89	191.19
Bathing	Full Assist plus	354.81	372.55	381.12
	2 Person Assist 2:1 RATE	354.81	372.55	381.12
Oral Hygiene	Full Assist	88.42	92.84	94.98
Dressing & Hair Care	Full Assist	236.54	248.37	254.08
Shaving	Full Assist	118.26	124.17	127.03

B) Medical Section:					
Maximum Section Rate Allowed (Before 2:1 Rate)			\$ 4,285.54	\$ 4,499.82	\$4,603.31
Supports Title	Level of Assist	Supports Value	7/1/2020	7/1/2021	4/1/2022
Communication - Expressive	Full Assist		354.81	372.55	381.12
Communication - Receptive	Full Assist		354.81	372.55	381.12
Safety	Full Assist		532.79	559.43	572.30
Fire Evacuation	Full Assist		17.23	18.09	18.51
Medication Management Support Oral	Full Assist 5 or 6		177.99	186.89	191.19
	Full Assist 7 or more		354.81	372.55	381.12
Medication Management Support Inhalants, Topicals or Suppositories	Partial Assist		177.99	186.89	191.19
	Full Assist		354.81	372.55	381.12
Health Management Supports - General	Full Assist		177.99	186.89	191.19
Health Management Supports - Complex	Partial Assist - Weekly		354.81	372.55	381.12
	Partial Assist - 1 to 3 per days		710.78	765.48	729.54
	Full Assist 3 per day		2,132.32	2,238.94	2290.44
	Full Assist & Monitoring Exclusive Focus		4,264.63	4,477.86	4,580.85
	2 Person Assist & Monitoring Exclusive Focus (+ 2:1)		4,264.63	4,477.86	4,580.85

Equipment (considered part of the medical section): The value of the highest price item is yielded for each section.			
Maximum Allowed for this Equipment Section: described in table	7/1/2020	7/1/2021	4/1/2022
Leg Braces	30.40	31.92	32.65
Ankle or Foot Orthotics	30.40	31.92	32.65
Arm Splints	30.40	31.92	32.65
Grab bars in bathroom	60.79	63.83	65.30
Shower Gurney	60.79	63.83	65.30
Hoyer Lift	120.46	126.48	129.39
Transfer Boards	120.46	126.48	129.39
Body Jacket	60.79	63.83	65.30
Manual Wheelchair	30.40	31.92	32.65
Electric Power Wheelchair	30.40	31.92	32.65
Prone Stander	30.40	31.92	32.65
Sidelyer	30.40	31.92	32.65
Nebulizers	60.79	63.83	65.30
C-PAP	60.79	63.83	65.30

Oxygen	60.79	63.83	65.30
Ventilator	120.46	126.48	129.39
Pulse Oxymeter	30.40	31.92	32.65
Heart Monitor	30.40	31.92	32.65
Suctioning Equipment	120.46	126.48	129.39
Vagal Stimulator	60.79	63.83	65.30
Diabetic insulin pump	60.79	63.83	65.30
Baclofen pump	30.40	31.92	32.65
Prosthetics	12.39	13.01	13.31

C.) Nighttime Needs Section:					
Maximum Rate Allowed before 2:1 needs			\$ 2,487.12	\$ 2,611.48	\$ 2,671.54
Supports Title	Level of Assist for Night time Needs	Supports Value	7/1/2020	7/1/2021	4/1/2022
Nighttime Needs Medical Support	Assists Weekly	354.81	372.55	381.12	
	Assists Intermittently Nightly	1,065.59	1118.87	1144.60	
	Assists Ongoing Nightly	2,132.32	2238.94	2290.43	
	1:1 Assist	2,487.12	2611.48	2671.54	
	2:1 Assist; plus 2:1 Rate	2,487.12	2611.48	2671.54	
Nighttime Needs Behavior Support	Assists Weekly	354.81	372.55	381.12	
	Assists Intermittently Nightly	1,065.59	1118.87	1144.60	
	Assists Ongoing Nightly	2,132.32	2238.94	2290.43	
	1:1 Assist	2,487.12	2611.48	2671.54	
	2:1 Assist; plus 2:1 Rate	2,487.12	2611.48	2671.54	

D.) Behavioral Needs Section					
Maximum Rate Allowed before 2:1 needs			\$ 4,264.63	\$ 4,477.86	\$ 4,580.85
Supports Title	Level of Assist for Behavioral Needs	Supports Value	7/1/2020	7/1/2021	4/1/2022
Behavior Supports - No Formal Plan Supervision & Monitoring	Within Hearing or Visual distance	532.79	559.43	572.30	
	Within Hearing & Visual distance	710.78	746.32	763.48	
Behavior Supports - Home and Community	Behavior Plan - no physical intervention	354.81	372.55	381.12	
	Behavior Plan	710.78	746.32	763.48	
	Mental Health Plan	710.78	746.32	763.48	
Behavior Supports - Supervision Home	Within Hearing or Visual distance	532.79	559.43	572.30	
	Within Hearing & Visual distance	710.78	746.32	763.48	

APPENDIX B
Oregon Health Authority and Addictions and Mental Health Division Adult Foster Home Base Rate and Add-Ons Table

B.1 RATE TABLE

All rates outlined below, and currently existing Exceptional rates, shall be adjusted in accordance with the COLA in Article 9.

Effective July 1, 2021, rates will be calculated utilizing the LSI as follows:

LSI Score	Base Rate	1St Score	Base Rate	LSI Score	Base Rate
0-34	\$ 2,029	35-79	\$ 2,549	80-100	\$ 3,245
ADD ON 1	\$ 2,079	ADD ON 1	\$ 2,639	ADD ON 1	\$ 3,392
ADD ON 2	\$ 2,130	ADD ON 2	\$ 2,731	ADD ON 2	\$ 3,543
ADD ON 3	\$ 2,184	ADD ON 3	\$ 2,827	ADD ON 3	\$ 3,702
ADD ON 4	\$ 2,239	ADD ON 4	\$ 2,925	ADD ON 4	\$ 3,869
ADD ON 5	\$ 2,294	ADD ON 5	\$ 3,027	ADD ON 5	\$ 4,044
ADD ON 6	\$ 2,351	ADD ON 6	\$ 3,133	ADD ON 6	\$ 4,226
		ADD ON 7	\$ 3,243	ADD ON 7	\$ 4,416

Effective April 1, 2022, rates will be calculated utilizing the LSI as follows:

LSI Score	Base Rate	1St Score	Base Rate	LSI Score	Base Rate
0-34	\$ 2,075	35-79	\$ 2,608	80-100	\$ 3,319
ADD ON 1	\$ 2,127	ADD ON 1	\$ 2,699	ADD ON 1	\$ 3,470
ADD ON 2	\$ 2,179	ADD ON 2	\$ 2,794	ADD ON 2	\$ 3,624
ADD ON 3	\$ 2,234	ADD ON 3	\$ 2,892	ADD ON 3	\$ 3,787
ADD ON 4	\$ 2,290	ADD ON 4	\$ 2,993	ADD ON 4	\$ 3,958
ADD ON 5	\$ 2,347	ADD ON 5	\$ 3,097	ADD ON 5	\$ 4,137
ADD ON 6	\$ 2,405	ADD ON 6	\$ 3,205	ADD ON 6	\$ 4,323
		ADD ON 7	\$ 3,318	ADD ON 7	\$ 4,518

B.2 EXCEPTIONAL NEEDS CLIENTS

In recognition of the increased services or staffing needs required to provide safe and effective care to certain high-needs individuals on a time-limited basis, providers will receive an additional \$16.67 per hour for every hour an individual requires and receives 1:1 services or staffing as recommended by an individual's psychiatrist, -Mental Health Psychiatric Nurse Practitioner (MHPNP) or other Clinician and approved by the Rate Review Committee (RRC). Effective January 1, 2023, this rate will increase to \$17.77. (These rates are based on the rates paid to state-paid homecare providers.) This payment is in addition to any add-ons in the table in B.1 of this Appendix.

As these services/supports are intensive and time limited, approval from the RRC will not exceed a one hundred and twenty (120)-day authorization period- If services or staffing is needed beyond the authorization, the provider will need to again submit an RRC request.

To submit an RRC request, provider must submit the request using the OHA-approved request form along with the following documentation:

1. Recommendation from psychiatrist, or Mental Health Psychiatric Nurse Practitioner (MHPNP), or clinician that includes:
 - a. Identified services assessed as needed that requires additional support or 1:1 staffing;
 - b. Specific number of hours per day and when the services or staffing is needed;
 - c. duration of additional services or staffing; and
 - d. expected benefit and outcome of additional services or staffing.
2. Appropriate documentation to support the need for 1:1 services or staffing which may include the following, when available to the provider:
 - a. Most recent LSI completed by OHA's Independent Qualified Agent;
 - b. Most recent LOCUS from CMHP/CCO clinician;
 - c. Current treatment plan;
 - d. Current Person-Centered Service Plan (PCSP);
 - e. Current mental health assessment including current history and physical;

- f. Provider needs synopsis;
 - g. CMHP needs synopsis;
 - h. Progress Notes;
 - i. Medication Orders and Medication Administration Record (MAR);
 - j. Incident Reports;
 - k. Individually Based Limitations (IBL) as applicable; and
 - l. Other documentation as appropriate.
3. If a provider is submitting a request to continue an exceptional rate, the provider will submit the following documents and information:
- a. An attestation from the client's psychiatrist, Mental Health Psychiatric Nurse Practitioner (MHPNP), or clinician indicating that the client's condition hasn't substantially changed
 - b. Progress Notes;
 - c. Medication Orders and Medication Administration Record (MAR)

The State will provide the Union, on a quarterly basis, the number of approvals and denials for exceptional needs rates. The State will provide the Union with the criteria it uses to determine whether to grant or deny Exceptional Needs requests.

B.3 DETERMINATION OF RATES

The Level of Service Inventory, Mental Health Adult Foster Home User Manual will be used for determine the LSI scores, add-ons, and the calculation of rates.

REV: 2021

APPENDIX C
Service Rates for Adult Foster Homes Serving Individuals in Aging and People with Disabilities Programs

Rates will be paid as follows:

C.1 APD RATE TABLE

	Rate Per Month	
	Effective July 1, 2021	Effective April 1, 2022
Base	\$1,889	\$1,932
Base plus 1 add-on	\$2,232	\$2,284
Base plus 2 add-ons	\$2,576	\$2,635
Base plus 3 add-ons	\$2,919	\$2,986
Add-on Rate	\$343	\$351
	Rate Per Hour	
Approved additional hours of service	\$16.67	\$17.77

C.2 APD PAYMENTS

APD will pay a Base Rate with up to one (1) Add-on in each of the categories of: ADL, Behavior and Complex Medical needs (three (3) Add-on Maximum).

Requests for payment for additional assessed needs which require staffing beyond standard Add-ons must go through the exceptional rates process, be prior approved and will be paid the additional hours of service rate in the rate table with proof of hiring and continued employment. Changes to exceptional rates based on the change in the “additional hours of service rate” will be updated at time of annual reassessment, or as a change in condition occurs, based on Department approval of the exceptional needs request. Exceptional hours shall adequately meet resident service needs and adequately fund this service for Providers.

Based on the assessment of the Individual, by the State or its designee, APD may pay pass-through funding for additional service/s for Individuals that are not included in the AFH rate. Pass-through funding may be approved for non-ADL/IADL supports.

C.3 ADD ON CRITERIA

DHS will post add-on criteria on the Provider Tools website, notify AFHs about the location of the information and will train case managers on appropriate application of the add-on criteria.

C.4 AFH-SPECIFIC NEEDS CONTRACT AND EXCEPTIONAL RATES

Specific Needs Contract and Exceptional Rates are outside of the standardized APD-AFH rate structure and have their own distinct rate schedule defined below. Some of the specific needs covered under these contracts include: Ventilator Dependent, Neurological/Neuro-gerontologic, Brain Injury, Behavioral Needs, Bariatric, Complex ADL, Enhanced Care Outreach Services, and Cognitive/Memory Care.

Target Population	Rate Per Month	
	Effective July 1, 2021	Effective April 1, 2022
ECOS	\$3,413	\$3,419
Basic	\$7,615	\$7,790
Advanced	\$8,703	\$8,904
Ventilator	\$10,880	\$11,130
Complex	\$11,177	\$11,434

The Specific Needs such as memory care, bariatric care, brain injuries, complex medical, complex ADL or neurological conditions may fall into the Basic, Advanced or Complex rate categories, depending on care and staffing needs of the Individuals served under that contract.

AFHs receiving AFH Specific Needs Contracts must comply with the contracted Statement of Work. Rates will only be provided for Individuals living in the AFH who meet the service and eligibility criteria specified in the Statement of Work and approved by APD Central Office. Specific Needs Contracts will require additional staffing, services and

ongoing documentation of compliance with the Statement of Work as defined by the State.

Specific Needs Provider Compliance Process:

By July 1, 2020 the State shall develop a checklist of items that will be reviewed during the routine Contract Compliance Process.

Providers shall be notified thirty (30) days in advance of an upcoming compliance process. Providers shall have fifteen (15) business days from initial notification of the compliance process to provide requested documentation.

By July 1, 2020 the State shall provide Specific Need Providers access to example forms for use in the SNP homes.

If the requirements of the Specific Needs Contracts are not met, Specific Needs Contract may be terminated. Before Specific Needs Contracts are terminated, Providers will have the opportunity to come into compliance with the contract unless the contract violation possesses an imminent risk to the Individual/s in the AFH, as determined by the State. Providers will have no more than sixty (60) days to come into compliance before termination of the Specific Needs Contract.

For multiple related occurrences of intentional non-compliance the State may terminate the contract as specified in the Specific Needs Contract.

Appropriate transition plans including necessary funding through the exceptional rates process will be made if the assessed needs of the Individual continue to demonstrate the higher needs. The current Specific Needs Contract rate shall continue until Individuals are transferred out of the AFH or an exceptional rate has been established, if necessary. The Department retains sole discretion in determining Exceptional Rate and Specific Need Contract Providers.

CONTACT PAGE

APD (800) 241-3013

DD (503) 373-2227, otherwise go through the local office

OHA (503) 945-5600

MRC (844) 734-8255

*** Please note that there is not one number that addresses all situations. You may be referred to another number to address your specific issue.

SIGNATURE PAGE – SEIU – ADULT FOSTER HOME PROVIDERS

Signed this 9th day of February 2022, at Salem, Oregon.



FOR THE STATE OF OREGON:

Katy Coba

Katy, Coba, Director
Department of Administrative Services (DAS)

Nadja Gulley

Nadja Gulley, State Labor Relations Manager
DAS CHRO Labor Relations

Madilyn Zike

Madilyn Zike, Chief Human Resources Officer
DAS Chief Human Resources Office (CHRO)



FOR THE SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 503:

DocuSigned by:

Melissa Unger

Melissa Unger, Executive Director
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The official version of this Agreement is held by the Department of Administrative Services Labor Relations Unit on its electronic files at the website below. The Department of Administrative Services does not recognize any other copies or publications of this Agreement.

Electronic version of the Agreement located at:
<http://www.oregon.gov/das/HR/Pages/LRU.aspx>