

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A state has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Oklahoma** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:

In-Home Supports Waiver for Children

C. Waiver Number:OK.0351

Original Base Waiver Number: OK.0351.

D. Amendment Number:OK.0351.R05.10

E. Proposed Effective Date: (mm/dd/yy)

07/01/26

Approved Effective Date: 07/01/26

Approved Effective Date of Waiver being Amended: 07/01/22

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Appendix B, the Evaluation/Reevaluation of Level of Care has been updated. The qualifications for initial level of care evaluators and annual level of care evaluators have been updated to allow for a Bachelors degree in any field and years of experience to be substituted in lieu of the degree.

Appendix D, the Service Plan Development section has been updated. The qualifications for a case manager have been updated to allow for a Bachelors degree in any field and years of experience to be substituted in lieu of the degree. References to an annual medical report have been removed.

Appendix D, removed references to a medical assessment, as an annual medical assessment will no longer be required.

Appendix G, a.i.d, the second performance measure has been removed from the Quality Improvement Strategy, "Number and percent of member's records reviewed that had an annual medical report. Numerator: Number of member's records reviewed that had an annual medical report. Denominator: Total number of member's records reviewed."

Appendix G, the following areas have been updated:

G-1:b. State Critical Event or Incident Reporting Requirements section has been updated.

Appendix J, estimates for ALOS, number of users, average units per user, and rates have been updated for Waiver Year 5.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A - Waiver Administration and Operation	
☒ Appendix B - Participant Access and Eligibility	6-c; 6-h
☒ Appendix C - Participant Services	1-a
☒ Appendix D - Participant Centered Service Planning and Delivery	1-a, d-i
☐ Appendix E - Participant Direction of Services	
☐ Appendix F - Participant Rights	
☒ Appendix G - Participant Safeguards	1-b

Component of the Approved Waiver	Subsection(s)
☐ Appendix H	
☐ Appendix I - Financial Accountability	
☒ Appendix J - Cost-Neutrality Demonstration	2-b, c-i, c-ii, c-iii, c-iv;d-1.i

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- ☐ Modify target group(s)
☐ Modify Medicaid eligibility
☒ Add/delete services
☐ Revise service specifications
☒ Revise provider qualifications
☐ Increase/decrease number of participants
☒ Revise cost neutrality demonstration
☐ Add participant-direction of services
☒ Other
Specify:

Update Quality Improvement Strategy and State Critical Event or Incident Reporting Requirements.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Oklahoma** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

In-Home Supports Waiver for Children

C. Type of Request: amendment

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

☐ 3 years
☒ 5 years

Original Base Waiver Number: OK.0351

Waiver Number: OK.0351.R05.10

Draft ID: OK.002.05.08

D. Type of Waiver (*select only one*):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/22

Approved Effective Date of Waiver being Amended: 07/01/22

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and

07/16/2026

community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

☒ **Hospital as defined in 42 CFR § 440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

☒ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☐ **Nursing Facility**

Select applicable level of care

☒ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

☒ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs)

approved under the following authorities

Select one:

☒ **Not applicable**

☐ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under section 1915(b) of the Act.**

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

Specify the section 1915(b) authorities under which this program operates (check each that applies):

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under section 1915(i) of the Act.**

☐ **A program authorized under section 1915(j) of the Act.**

☐ **A program authorized under section 1115 of the Act.**

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The In-Home Supports Waiver for Children (IHSW-C) serves individuals age 3-17 through a combination of community resources, SoonerCare services such as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, and waiver services. DHS/DDS Case Managers help identify concerns and coordinate, locate and secure needed services. DHS/DDS Case Managers also help families recognize natural supports that may already be available.

The purpose of the IHSW-C is to assist members in their goal to lead healthy, independent, and productive lives to the fullest extent possible; promote the full exercise of their rights as citizens of their community, State, and Country; and promote the integrity and well-being of their families. Services are provided with the goal of promoting independence through the strengthening of the member's capacity for self-care and self-sufficiency. The IHSW-C is a service system centered on the needs and preferences of the members and supports the integration of members within their communities. In addition to other eligibility requirements, to be eligible for services funded through the IHSW-C a person must reside in the home of a family member or friend, his or her own home, and have critical support needs that can be met through a combination of non-paid, non-waiver, and State Plan resources available to the member, and with Home and Community-Based Services (HCBS) waiver resources that are within the annual limit.

The Developmental Disabilities Services (DDS) of the Oklahoma Department of Human Services (DHS), through an Interagency Agreement with the Oklahoma Health Care Authority (OHCA), the States Single Medicaid Agency, operates the IHSW-C for individuals with an intellectual disability. This waiver provides services and payment for those services that are not otherwise covered through Oklahoma's Medicaid State Plan, hereinafter referred to as SoonerCare. In-Home Supports Waiver for Children services, when used in conjunction with non-waiver SoonerCare services and other generic services and natural supports, provide for the health and developmental needs of members who otherwise would not be able to reside in a home or community-based setting. The Waiver is operated on a statewide basis. Case Management (CM) services are provided as Targeted Case Management by employees of DHS/DDS. DHS/DDS Case Managers are located in offices throughout the state. These Case Managers assure that members are assessed and their needs are identified and documented and also coordinate the Personal Support Team (Team), as described in Appendix D-1:c, for each member.

The services and supports provided are identified by the member, his/her legal representative or family member(s) and other members of the Team, as described in Appendix D-1:c, during the meeting to develop the Individual Plan. A DHS/DDS Case Manager develops a plan of care in accordance with the DHS Individual Plan policy, Oklahoma Administrative Code (OAC) 340:100-5-53. The Individual Plan contains descriptions of the services provided, documentation of the amount, frequency and duration of services, and the types of service providers. Services are authorized based on service authorization policy, OAC 340:100-3-33 and 33.1. Services are provided by qualified provider entities who have entered into Agreements with OHCA. The DHS/DDS Case Manager assists the member to select providers of their choice. The Case Manager also coordinates and monitors the provision of these services in accordance with the Individual Plan and makes necessary changes to assure the health and welfare of the member. Members are given the option of choosing to self direct some services. Members who choose this option develop an individualized budget, with the assistance of the DHS/DDS Case Manager, for services they self direct. Each member (or their personal representative) has both employment and budget authority over the self directed services.

Habilitation Training Specialist (HTS) services are authorized in an acute care hospital, by the 1915(c) HCBS provider, per the CARES Act when the service is:

- (A) identified in the member's person-centered plan of services and supports;
- (B) not duplicative of services available in the acute care hospital setting;
- (C) provided to meet needs of the member that are not met through the provision of hospital services;
- (D) not a substitute for services the hospital is obligated to provide through its conditions of participation or under Federal or State law; (E) designed to ensure smooth transitions between acute care settings and home and community-based settings; and
- (F) when the service will assist the member in preserving function and returning to the community.

The rate for the HTS service is the same regardless of where the service is delivered.

The Quality Assurance Unit of DHS/DDS monitors quality of services provided and monitors the satisfaction of the persons served. OHCA audits member plans of care on an as needed basis, with a referral, to ensure waiver services are provided in the manner required by policy.

3. Components of the Waiver Request

The waiver application consists of the following components. Note: Item 3-E must be completed.

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- ☒ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

☐ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*
- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the quality improvement strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- ☐ Not Applicable
- ☒ No
- ☐ Yes
- C. Statewide.** Indicate whether the state requests a waiver of the statewide requirements in section 1902(a)(1) of the Act (*select one*):
- ☒ No
- ☐ Yes
- If yes, specify the waiver of statewide that is requested (*check each that applies*):
- ☐ **Geographic Limitation.** A waiver of statewide is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- ☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.

Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR § 441.302, the state provides the following assurances to CMS:

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the

waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

The following processes and forums have provided opportunities for public input to the waiver amendment process:

7-1-26 AMENDMENT - The following processes and forums have provided opportunity for public input to the waiver amendment process:

To fulfill the non-electronic requirements for public comment, the State posted written notices in all county offices, ensuring meaningful opportunities for input for individuals served or eligible to be served under the waiver. The public notice contained a summary of the changes, along with a copy of the entire waiver application and instructions on how individuals could submit comments. This comment period was open from February 2, 2026, to March 3, 2026. No public comments were received during this period; therefore, no comments were adopted.

The In-Home Supports Waiver for Children was placed on the OHCA website for public comment from February 2, 2026, to March 3, 2026. The waiver was posted at <https://oklahoma.gov/ohca/policies-and-rules/public-notice.html>. No public comments were received during this period; therefore, no comments were adopted.

On January 6, 2026, OHCA held a Tribal Consultation on the proposed waiver renewal. The item requested a tribal consultation comment period from January 7, 2026, to March 9, 2026. Comments about the proposed policy change were directed to the online comment system found on the Policy Change Blog and/or the Native American Consultation Page. No public comments were received during this period; therefore, no comments were adopted.

The OHCA Long Term Care Quality Initiative Council/Living Choice Advisory Council met on February 19, 2026. No public comments were received at this meeting; therefore, no comments were adopted.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the state of the state's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Ward

First Name:

David

Title:
Long Term Services and Supports (LTSS) Sr. Director

Agency:
Oklahoma Health Care Authority

Address:
4345 N. Lincoln Blvd.

Address 2:

City:
Oklahoma City

State:
Oklahoma

Zip:
73105

Phone:
(405) 522-7776 Ext: ☐ TTY

Fax:
(405) 530-7722

E-mail:
David.Ward@okhca.org

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:
Murray

First Name:
Beverly

Title:
Medicaid Services Director

Agency:
Oklahoma Department of Human Services

Address:
2400 N. Lincoln Blvd.

Address 2:

City:
Oklahoma City

State:
Oklahoma

Zip:
73125

Phone:
(405) 238-0191 Ext: ☐ TTY

Fax:

(405) 522-3221

E-mail:

Beverly.Murray@okdhs.org

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

Melissa Miller

State Medicaid Director or Designee

Submission Date:

Jun 8, 2026

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

Miller

First Name:

Melissa

Title:

State Medicaid Director

Agency:

Oklahoma Health Care Authority

Address:

4345 N. Lincoln Blvd

Address 2:

City:

Oklahoma City

State:

Oklahoma

Zip:

73105

Phone:

(405) 693-8260

Ext: ☐ TTY

Fax:

(405) 530-7722

E-mail:

Attachments

melissa.miller@okhca.org

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ Replacing an approved waiver with this waiver.
- ☐ Combining waivers.
- ☐ Splitting one waiver into two waivers.
- ☐ Eliminating a service.
- ☐ Adding or decreasing an individual cost limit pertaining to eligibility.
- ☐ Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- ☐ Reducing the unduplicated count of participants (Factor C).
- ☐ Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- ☐ Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- ☐ Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix B QIS Sub-assurance (a)continued: D: Total number of applicants for whom there is reasonable indication that services may be needed in the future.
 Appendix B QIS Sub-assurance (c)continued: D: Total number of member's initial level of care evaluations.
 Appendix C QIS Sub-assurance (c)continued: D: Total number of direct support agency providers.
 Appendix C QIS Sub-assurance (c)continued: D: Total number of direct support agency providers.
 Appendix D QIS Sub-assurance (c)continued: D: Total number of member's records reviewed.
 Appendix G QIS Sub-assurance (d)continued: D: Total number of member records reviewed.

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

- ☒ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- ☒ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

- ☐ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Oklahoma Department of Human Services, Developmental Disabilities Services

In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The single State Medicaid Agency, OHCA, and the operating agency, DHS, have entered into an Interagency Agreement to assure cooperation and collaboration in performance of their respective duties in the provision of waiver services. The purpose of this Agreement is to satisfy State and Federal requirements regarding the role of OHCA and DHS, to outline financial obligations and arrangements between these agencies, and to define the roles of each agency. OHCA performs continuous monitoring of DHS following a monthly reporting schedule. However, additional monitoring, if required, occurs on an as needed basis.

The Interagency Agreement between OHCA and DHS is reviewed at least annually. Amendments can be executed as warranted at any time.

Responsibilities afforded to OHCA as related to fiscal matters are outlined in Oklahoma Administrative Code (OAC) 317:30. OHCA works with DHS to establish rates for waiver services. The OHCA Board of Directors has final approval of all proposed rates and rate changes. OHCA monitors waiver expenditures and enrollment monthly using data in the MMIS.

The OHCA Level of Care Evaluation Unit (LOCEU) conducts the initial screening/evaluation to determine or confirm a member's level of care, including verifying a diagnosis of Global Developmental Delay or intellectual disability, and approves/denies waiver eligibility. DHS/DDS Level of Care Reviewers perform re-evaluations unless a significant change occurs which questions the qualifying diagnosis of a member. In those cases, information is submitted to OHCA LOCEU for reevaluation. For children under the age of six, a new psychological evaluation must be conducted and submitted after the child reaches six years of age. Re-evaluation occurs at the beginning of the plan of care year following the child's sixth birthday, at which time, a diagnosis of Intellectual Disability must be confirmed in order to continue waiver services.

DHS/DDS conducts an audit which specifically includes a review of re-evaluations and reports findings to OHCA. OHCA representatives meet regularly with staff of DDS. DDS provides regular summary reports reviewing discovery and remediation activities for the indicators in the Quality Improvement Strategy including those for the level of care and end of year summary data for all quality indicators. Discussion of any identified issues or trends and suggestions for systems or other remediation or improvements are shared.

DHS/DDS gathers information to verify non-licensed provider applications meet provider qualifications prior to submission to OHCA for final provider Agreement approval.

OHCA enters into Agreements with providers and verifies provider qualifications upon enrollment into the waiver program. Oklahoma has numerous Boards or agencies that license certain health practitioners. OHCA's provider Agreement requires providers to notify OHCA if their license is suspended, revoked or any other way modified by the licensing Board/agency. Additionally, on a monthly basis, OHCA Provider Enrollment staff receive a file from the Centers for Medicare & Medicaid Services (CMS) that lists sanctioned providers. This listing is compared against OHCA's master provider file, and sanctioned providers are removed from participation in the waiver program as of the effective date of the sanction. All new providers wishing to participate in the waiver program are also checked against this listing.

In accordance with the Interagency Agreement, OHCA and DHS/DDS coordinate policy issues related to the operation of the waiver program including changes in policy and procedures. All proposed rules are reviewed and approved by the Advisory Committee on Services to Persons with Developmental Disabilities (ACSPDD), of which OHCA is a participating member. The ACSPDD reviews all policies of DHS/DDS and makes recommendations to the Director of Human Services. Statutory authority of the ACSPDD is Section 1412 of Title 10 of the Oklahoma Statutes. All proposed rules are also reviewed and approved by the OHCA Medical Advisory Committee; and the OHCA Board prior to submission to the Governor for final approval.

DHS/DDS monitors non-licensed providers for compliance and provides results to OHCA.

OHCA is notified when Administrative Inquiries and follow-ups as well as annual performance reviews and follow-ups are completed. DHS/DDS Quality Assurance Unit also monitors the performance of DHS/DDS by conducting performance reviews of DHS/DDS member records to ensure member services are provided in an amount, duration and frequency which supports member Plans. Results of DHS/DDS Case manager reviews are sent by email to OHCA. OHCA representatives are provided summary reports to review quality indicators on a

regular basis. Follow-ups are sent to OHCA as they are completed.

The Area Survey monitoring process is a record review of the DHS/DDS Case Manager record, based on a statistically significant random sample of members receiving supports through the waiver. One quarter of the representative sample is monitored each quarter. This results in a complete representative sample being reviewed each year. The record reviews include a review of service plans to assure: all member needs are addressed and preferences considered; they are developed according to policy and updated/revised as needed ensuring an interim meeting was held within 30 days of identification or notification of the need for change in authorization of waiver services; services are delivered in accordance with the service plan including the type, scope, amount and frequency specified in the service plan; and that members are afforded choice between waiver services and institutional care and between/among waiver services and providers. The Area Survey record reviews provide a process for monitoring the health and welfare of members, assuring Case Managers: conduct face-to-face visits as required; address issues that could put the member's health or welfare at risk; and provide follow-up on issues identified in incident reports. The results of the Area Survey monitoring process are shared with OHCA and included in summary reports.

The Performance Survey is an annual monitoring site visit in which all provider agencies participate, providing data based on an aggregated statistically significant sample of members receiving waiver services and an aggregated statistically significant sample of provider agency staff. The Performance Survey includes all waivers for which the provider agency contracts. Monitoring of service plan development and implementation includes: a review of provider agency records for a random sample of waiver members; and home visits and interviews with waiver members and other pertinent people, for those sampled. The annual monitoring of non-licensed/non-certified provider staff includes a review of personnel records for a sampling of staff assigned to provide supports, to ensure all required employment background checks have been obtained and all required training has taken place. The Performance Survey process provides for a sampling of financial records to ensure compliance with provider Agreements. DHS/DDS policy provides the expectation that all identified barriers to performance consistent with the expectation of regulatory policy and contracts are resolved no later than 60 days following the completion of the annual Performance Survey. Failure to correct identified barriers could result in administrative sanctions. The results of Performance Surveys are summarized and shared with OHCA in regular reports.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- ☒ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

DHS/DDS serves as a Financial Management Service (FMS) in a Government Fiscal Employer Agent (FEA) model and also operates as an Organized Health Care Delivery System (OHCDS) using a subagent. The subagent has entered into an Agreement with DHS/DDS and also OHCA to perform billing transactions on behalf of DHS/DDS. DHS/DDS has entered into an Interagency Agreement with OHCA.

- ☐ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- ☒ **Not applicable**
- ☐ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

- ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

- ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

DHS/DDS is responsible for assessment of performance of the Financial Management Service (FMS) subagent as identified in Appendix A.3. The FMS subagent is also subject to monitoring and oversight by the Oklahoma Health Care Authority (OHCA), the State's Medicaid agency.

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The Financial Management Service (FMS) subagent maintains adequate and separate accounting and fiscal records and accounts for all funds provided by any source to pay the cost of the project and permit audit and/or examination of all such records, procedures and accounts at any reasonable time by authorized personnel of the U.S. Department of Health and Human Services or other pertinent Federal agencies and authorized personnel of the Oklahoma Department of Human Services, State Auditor and Inspector and other appropriate State entities. Furthermore, such personnel have the right of access to any books, records, documents, accounting procedures, practices or any other items of the service provider that are pertinent to the performance or payment of the contract in order to audit, examine and make excerpts of records. Contractor is required to maintain all records for six years after the Department makes final payment and all other pending matters are closed. DHS/DDS will be responsible for assessment of performance of the FMS subagent. The FMS subagent is required to submit a monthly report to the DHS/DDS Contract Monitor for the FMS subagent. The report includes the names of all members served. The report is compared with DHS/DDS records of authorization and upon completion of review is submitted to the DHS Finance Division. The report is shared with OHCA upon request. In addition, a monthly report is available via the web with a login and password to members and DHS/DDS by the FMS subagent which includes statement period, member name, name and address used to mail the statement, a listing of all active accounts, total amount of money FMS subagent has received via authorization, spending via statement period, total amount of spending and the balance of account. The FMS subagent is also subject to monitoring and oversight by the Oklahoma Health Care Authority (OHCA), the State's Medicaid agency. Reports are due monthly and more frequently upon request.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☒	☒	☐
Waiver enrollment managed against approved limits	☒	☒	☐
Waiver expenditures managed against approved levels	☒	☒	☒
Level of care waiver eligibility evaluation	☒	☒	☐
Review of Participant service plans	☒	☒	☐
Prior authorization of waiver services	☒	☒	☐
Utilization management	☒	☒	☐
Qualified provider enrollment	☒	☒	☐
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☐	☐
Rules, policies, procedures and information development governing the	☒	☒	☐

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
waiver program			
Quality assurance and quality improvement activities	☒	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of provider Agreement applications for non-licensed providers for which DHS/DDS verified provider information prior to approval by OHCA and initiation of provider Agreement. Numerator: Number of non-licensed provider applications verified by DHS/DDS prior to approval by OHCA and initiation of agreement. Denominator: Total non-licensed provider applications received.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DHS/DDS report

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review

☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of monthly enrollment reports submitted to and reviewed by OHCA that are within approved levels. Numerator: Number of monthly enrollment reports submitted to and reviewed by OHCA that are within approved levels. Denominator: Total number of monthly enrollment reports.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly	☒ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of required provider performance monitoring reviews conducted by DHS/DDS and reported to and reviewed by OHCA. Numerator: Number of required provider performance monitoring reviews conducted by DHS/DDS and reported to and reviewed by OHCA. Denominator: Total number of required provider performance monitoring reviews conducted by DHS/DDS.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DHS/DDS report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of fixed service rates submitted to OHCA and approved for DHS/DDS by the OHCA Board of Directors. Numerator: Number of fixed service rates submitted to OHCA and approved for DHS/DDS by the OHCA Board of Directors. Denominator: Total number of fixed service rates submitted to OHCA.

Data Source (Select one):**Program logs**

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review

☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of administrative reports furnished within 45 working days of the close of the quarter to the State Medicaid Director and Waiver Administration Unit.
Numerator: Number of administrative reports furnished within 45 working days of the close of the quarter. **Denominator:** Total number of administrative reports furnished to the State Medicaid Director and Waiver Administration Unit.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Report prepared by DHS/DDS

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of provider Agreement applications for licensed providers for which DHS/DDS verified appropriate licensure prior to approval by OHCA and initiation of provider Agreement. Numerator: Number of provider Agreement applications for licensed providers for which DHS/DDS verified appropriate licensure. Denominator: Total number of licensed provider Agreement applications.

Data Source (Select one):

Other

If 'Other' is selected, specify:

DHS/DDS report

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and	☐ Other

	Ongoing	Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of monthly prior authorizations submitted to and reviewed by OHCA that are within approved levels. Numerator: Number of monthly prior authorizations submitted to and reviewed by OHCA that are within approved levels. Denominator: Total number of monthly prior authorizations submitted.

Data Source (Select one):**Operating agency performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
☒ State Medicaid Agency	☐ Weekly	☒ 100% Review

☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of policy pertaining to DHS/DDS waiver members submitted to and approved by OHCA. Numerator: Number of policy pertaining to DHS/DDS waiver members submitted to and approved by OHCA. Denominator: Total number of policy pertaining to DHS/DDS waiver members submitted.

Data Source (Select one):

Program logs

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

OHCA's Long Term Services & Supports (LTSS) dedicated waiver staff are responsible for program monitoring and oversight and will address individual problems as they are discovered with regard to operations and administrative functions that are performed by all contracted entities. LTSS dedicated waiver staff will maintain administrative authority through the use of an electronic database designed for storing information received related to problems identified and resolution of these matters. The LTSS Contract Monitor will be directly responsible for mediating any individual problems pertaining to administrative authority. The LTSS Contract Monitor will work with the designated Contractor Point of Contact to resolve any problems in a timely manner. The LTSS Contract Monitor will have the use of penalties and sanctions in accordance with the terms of the contract. Problems requiring additional OHCA staff will be addressed in workgroups involving appropriate personnel to resolve issues timely and effectively.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☒ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☒ Continuously and Ongoing
	☐ Other

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

☒ **No**

☐ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☒	Intellectual Disability	3	17	☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

Services may be provided to children under the age of six, with a diagnosis of Global Developmental Delay. A new psychological evaluation must be conducted and submitted after the child reaches six years of age. Re-evaluation occurs at the beginning of the plan of care year following the child's sixth birthday, at which time, a diagnosis of Intellectual Disability must be confirmed in order to continue waiver services.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- ☐ **Not applicable. There is no maximum age limit**
- ☒ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

When a service member reaches age 18, the service member is disenrolled from the IHSW-C and automatically enrolled in the State's In-Home Supports Waiver for Adults (IHSW-A) in accordance with OAC 317:40-1-1. Service members transitioning from the IHSW-C to the IHSW-A are not subject to the waiting list.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ☐ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ☒ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is (*select one*)

- ☐ **A level higher than 100% of the institutional average.**

Specify the percentage:

- ☐ **Other**

Specify:

- ☐ **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ☒ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The In-Home Supports Waiver for Children (IHSW-C) serves individuals who live with family, friends or in their own home. The IHSW-C relies heavily on the use of natural and generic resources and supports. The support needs of the member must be able to be met through a combination of non-paid, non-waiver, SoonerCare resources available to the member, and with HCBS waiver resources that are within the annual limit.

The IHSW-C annual cost limit was first determined by an analysis of the costs of similarly situated members when the Waiver was initiated in State Fiscal Year (SFY) 1999. In subsequent operating years (Annual Reporting Periods), the annual cost limit was adjusted in conjunction with rate increases paid to service providers to ensure its continued relevance. The basis of the limit is based on historical use of EPSDT by children with an ICF-IID level of care combined with estimates of expected utilization of waiver services. The cost limit may be increased in the event of a service rate increase.

The cost limit specified by the state is (select one):

- ☒ **The following dollar amount:**

Specify dollar amount:

The dollar amount (select one)

- ☐ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

- ☐ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

- ☐ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

- ☐ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Prior to entrance to the waiver, DHS/DDS Intake Staff meet with the potential member, his/her family and/or legal representative(s) and any other person(s) chosen by the potential member. During the meeting, Intake Staff gather information about the potential member's strengths and needs and natural and generic supports and services available to determine the waiver services required by the potential member. The Individual Plan is completed at the meeting and is based on the principals of Person-Centered Planning. The Plan specifically identifies the needs of the potential member along with the available resources identified to meet those needs. In the event the waiver service needs of the potential member are greater than the annual cost limit of the IHSW-C, the potential member is referred for entrance to the Community Waiver, a waiver without an individual cost limit also administered by DHS/DDS, for individuals with an intellectual disability. If enrollment is denied, A Notice of Action form is mailed notifying the individual enrollment has been denied. The notice includes information regarding the right to request a Fair Hearing. In addition, the individual receives a pamphlet related to the Fair Hearing process during the Intake and eligibility process.

- c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- ☒ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☒ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

The Annual Limit may be increased for the following:

1. In the event of provider service rate increases occurring during a plan of care year resulting in individual plans of care exceeding the annual limit. The annual limit may be increased for that plan of care year by the impact of the rate increases. The annual limit may be increased for the subsequent plan of care year by the impact of the rate increases when necessary while a waiver amendment is pending. The State submits an amendment to increase the individual cost limit when a rate increase occurs.
2. When Assistive Technology Services or Environmental Accessibility Services were ordered under a previous year's plan but not delivered or completed until the current plan of care year. The current plan of care may exceed the annual limit by the cost of the previously-authorized Assistive Technology Services or Environmental Accessibility Services.
3. To allow for major purchases in excess of \$2,500 of Assistive Technology Services or Environmental Accessibility Services, but not to exceed a combined service limit of \$22,500.00 in any five year period.
4. To allow services authorized by the Oklahoma Department of Human Services (DHS) DDS State Office to resolve time-limited emergency situations after all other resources have been exhausted.

When services are needed beyond the scope identified above, the person is referred for entrance to the Community Waiver in accordance with Oklahoma Administrative Code (OAC) 317:40-1-1.

- ☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the

number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	638
Year 2	1108
Year 3	1204
Year 4	1400
Year 5	1600

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

- ☒ The state does not limit the number of participants that it serves at any point in time during a waiver year.
- ☐ The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The state *(select one)*:

- ☐ Not applicable. The state does not reserve capacity.
- ☒ The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes
Furnish waiver services to children experiencing crisis, as described in policy OAC 317:40-1-1

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (provide a title or short description to use for lookup):

Furnish waiver services to children experiencing crisis, as described in policy OAC 317:40-1-1

Purpose (describe):

Waiver services are made available for children experiencing crisis that pose risk to health and/or safety, as described in policy OAC 317:40-1-1.

Describe how the amount of reserved capacity was determined:

Reserved capacity is based on the number of children in crisis added to the waiver during the previous 12 months.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	15
Year 2	15
Year 3	15
Year 4	15
Year 5	15

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- ☒ The waiver is not subject to a phase-in or a phase-out schedule.
- ☐ The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

- ☒ Waiver capacity is allocated/managed on a statewide basis.
- ☐ Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the

waiver:

In accordance with OAC 317:40-1-1, initiation of services occurs in chronological order from the waiting list based on the date of receipt of a written request for services. The individual must meet the financial and medical eligibility criteria and have critical support needs that can be met by the IHSW-C. Exceptions to the chronological requirement may be made when an emergency exists.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a (*select one*):

- ☐ Section 1634 State
- ☒ SSI Criteria State
- ☐ 209(b) State

2. Miller Trust State.

Indicate whether the state is a Miller Trust State (*select one*):

- ☐ No
- ☒ Yes

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR § 435.217)

- ☐ Parents and Other Caretaker Relatives (42 CFR § 435.110)
- ☐ Pregnant Women (42 CFR § 435.116)
- ☐ Infants and Children under Age 19 (42 CFR § 435.118)
- ☒ SSI recipients
- ☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121
- ☒ Optional state supplement recipients
- ☒ Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- ☒ 100% of the Federal poverty level (FPL)
- ☐ % of FPL, which is lower than 100% of FPL.

Specify percentage:

- ☐ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage

Group as provided in section 1902(a)(10)(A)(ii)(XVI) of the Act)

- ☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 1902(e)(3) of the Act)
- ☐ Medically needy in 209(b) States (42 CFR § 435.330)
- ☐ Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)
- ☐ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Special home and community-based waiver group under 42 CFR § 435.217) Note: When the special home and community-based waiver group under 42 CFR § 435.217 is included, Appendix B-5 must be completed

- ☐ No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217. Appendix B-5 is not submitted.
- ☒ Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.

Select one and complete Appendix B-5.

- ☐ All individuals in the special home and community-based waiver group under 42 CFR § 435.217
- ☒ Only the following groups of individuals in the special home and community-based waiver group under 42 CFR § 435.217

Check each that applies:

- ☒ A special income level equal to:

Select one:

- ☒ 300% of the SSI Federal Benefit Rate (FBR)
- ☐ A percentage of FBR, which is lower than 300% (42 CFR § 435.236)

Specify percentage:

- ☐ A dollar amount which is lower than 300%.

Specify dollar amount:

- ☐ Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)
- ☐ Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)
- ☐ Medically needy without spend down in 209(b) States (42 CFR § 435.330)
- ☒ Aged and disabled individuals who have income at:

Select one:

- ☒ 100% of FPL
- ☐ % of FPL, which is lower than 100%.

Specify percentage amount:

- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR § 441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR § 435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR § 435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

- ☒ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under section 1924 of the Act.**

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

- ☒ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (select one):

- ☒ **Use spousal post-eligibility rules under section 1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- ☐ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- ☐ **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

- b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).**

The state uses the post-eligibility rules at 42 CFR § 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's

income:

i. Allowance for the needs of the waiver participant *(select one):*

- ☒ **The following standard included under the state plan**

Select one:

- ☐ **SSI standard**
- ☐ **Optional state supplement standard**
- ☐ **Medically needy income standard**
- ☒ **The special income level for institutionalized persons**

(select one):

- ☒ **300% of the SSI Federal Benefit Rate (FBR)**
- ☐ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

- ☐ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ☐ **A percentage of the Federal poverty level**

Specify percentage:

- ☐ **Other standard included under the state plan**

Specify:

- ☐ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- ☐ **The following formula is used to determine the needs allowance:**

Specify:

- ☐ **Other**

Specify:

ii. Allowance for the spouse only *(select one):*

- ☒ **Not Applicable**
- ☐ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (select one):

- ☐ SSI standard
- ☐ Optional state supplement standard
- ☐ Medically needy income standard
- ☐ The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

- ☐ The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

- ☐ Not Applicable (see instructions)
- ☒ AFDC need standard
- ☐ Medically needy income standard
- ☐ The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR § 435.811 for a family of the same size. If this amount changes, this item will be revised.

- ☐ The amount is determined using the following formula:

Specify:

- ☐ Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ☐ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ☒ **The state does not establish reasonable limits.**
- ☐ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

- c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).**

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

- d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)**

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under section 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

- ☐ **SSI standard**
- ☐ **Optional state supplement standard**
- ☐ **Medically needy income standard**
- ☒ **The special income level for institutionalized persons**
- ☐ **A percentage of the Federal poverty level**

Specify percentage:

- ☐ **The following dollar amount:**

Specify dollar amount:

If this amount changes, this item will be revised

- ☐ **The following formula is used to determine the needs allowance:**

Specify formula:

☐ Other

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR § 435.726 or 42 CFR § 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ☒ Allowance is the same
- ☐ Allowance is different.

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ☐ **Not Applicable (see instructions)** Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.
- ☒ **The state does not establish reasonable limits.**
- ☐ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).**

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

- g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).**

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR § 441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The state requires (select one):

- ☐ The provision of waiver services at least monthly
- ☒ Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (select one):

- ☐ Directly by the Medicaid agency
- ☐ By the operating agency specified in Appendix A
- ☐ By an entity under contract with the Medicaid agency.

Specify the entity:

● **Other**

Specify:

The OHCA Level of Care Evaluation Unit (LOCEU) performs all initial evaluations and reevaluations where there appears to be a significant change which questions a member's qualifying diagnosis. Annual reevaluations are conducted by DHS/DDS Level of Care Reviewers.

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR § 441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

To perform initial evaluations of level of care for waiver applicants, a person must have a bachelor's degree and 1 year of professional or technical administrative experience in business or public administration or an equivalent combination of education and experience, substituting 1 year of qualifying experience for each year of the required education.

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The OHCA Level of Care Evaluation Unit (LOCEU) uses the LTC-7 form (Disability and ICF/IID Level of Care Determination for a DHS/DDS Waiver) to determine an individual's institutional level of care need. To qualify for services, an individual must require active treatment per 42 CFR 483.440 and have substantial functional limitations in three or more of the following areas of major life activity: Self Care - The individual requires assistance, training, or supervision to eat, dress, groom, bathe, or use the toilet; Understanding and Use of Language - The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of request, or is unable to follow two-step instructions; Learning - The individual has a valid diagnosis of Intellectual disability as determined by the Social Security Administration (SSA) or the OHCA Level of Care Evaluation Unit. Mobility - The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without assistive device; Self-Direction - The individual is seven years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety, or for legal, financial, habilitative, or residential issues, and/or has been declared legally incompetent. The individual is a danger to himself or others without supervision; Capacity for Independent Living - The individual who is seven years old or older and is unable to locate and use a telephone, cross the street safely, or understand that it is unsafe to accept rides, food, or money from strangers. Or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping, or paying bills. Information used to conduct an initial evaluation is submitted to OHCA by the DHS/DDS Intake Case Manager. This information includes a psychological evaluation that includes a full scale functional and/or adaptive assessment and a statement of age of onset of the disability and intelligence testing that yields a full-scale intelligence quotient; a completed ICF-IID Level of Care Assessment form; and proof of disability according to SSA guidelines. If a disability determination has not been made by SSA, OHCA may make a disability determination using the same guidelines as SSA. Annual reevaluations are conducted by DHS/DDS Level of Care Reviewers unless a significant change has occurred which questions a member's qualifying diagnosis. In those cases, the same, but current, information used for the initial evaluation is submitted to OHCA for reevaluation. Relevant policy may be found at OAC 317:40-1-1.

- e. Level of Care Instrument(s).** Per 42 CFR § 441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**
 - **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR § 441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The same process is used for reevaluation as the initial evaluation except the DHS/DDS Level of Care Reviewer is responsible for conducting routine evaluations. The OHCA LOCEU conducts initial evaluations and reevaluations that question the qualifying diagnosis.

- g. Reevaluation Schedule.** Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- ☐ Every three months
- ☐ Every six months
- ☒ Every twelve months
- ☐ Other schedule

Specify the other schedule:

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- ☐ The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- ☒ The qualifications are different.

Specify the qualifications:

OHCA Level of Care Evaluation Unit staff must have a bachelor's degree and 1 year of professional or technical administrative experience in business or public administration or an equivalent combination of education and experience, substituting 1 year of qualifying experience for each year of the required education.

Annual reevaluations may be conducted by DHS/DDS Level of Care Reviewers. Requirements for a DHS/DDS Level of Care Reviewer consist of a Bachelor's degree in any field and one year of experience working directly with persons with intellectual disabilities or other developmental disabilities or in social work, case management, special education, psychology, counseling, vocational rehabilitation, physical therapy, occupational therapy, speech therapy, nursing or a closely related field; or possession of a valid permanent Oklahoma license as approved by the Oklahoma Board of Nursing to practice nursing and one year working directly with persons with intellectual disabilities or other developmental disabilities. Years of experience may be substituted in lieu of the bachelor's degree on a 1:1 basis.

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR § 441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

DHS/DDS case management software includes on-demand reporting available to all employees regarding reevaluations which are due within the next 30,60,90,120 or 365 days. The reports are used by DHS/DDS Case Managers and Level of Care Reviewers to identify necessary action. DHS/DDS Case Managers also use a tickler file system to assure timely reevaluations are conducted. Additionally, the training for and practice of DHS/DDS Case Managers is to prepare for reevaluations approximately 90 days prior to a member's annual Team, as described in Appendix D-1:c, meeting.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR § 441.303(c)(3), the state assures that written and/or

electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The DHS/DDS Case Manager maintains these records electronically in the case management information system.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. *Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

and percent of applicants for whom there is reasonable indication that services may be needed in the future who had a level of care determination. N: Number of applicants for whom there is reasonable indication that services may be needed in the future who had a level of care determination. Continued Main B Optional

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☒ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample

		Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

- b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.**

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.**

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of initial level of care evaluations that are accurately completed by a QIDP prior to receipt of services. Numerator: Number of initial level of care evaluations that are accurately completed by a QIDP prior to receipt of services. Denominator: Total number of initial level of care evaluations.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☒ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =

☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

and percent of member's initial level of care evaluations where the processes and instruments described in the waiver were applied appropriately and according to the approved description. N: # of member's initial level of care evaluations where the processes and instruments described in the waiver were applied appropriately and according to the approved description. Continued Main B Optional

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☒ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of initial level of care evaluations where level of care criteria was accurately applied prior to receipt of services. Numerator: Number of initial level of care evaluations where level of care criteria was accurately applied prior to receipt of services. Denominator: Total number of initial level of care evaluations.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☒ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:

	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The operating agency addresses individual problems as they are discovered and each problem is corrected. This may include directing case management to complete or gather required forms, ensuring the level of care was completed by a qualified person and following up to ensure the issue is corrected. Documents to support correction are maintained electronically in the DDS case management database. Data is analyzed to determine whether there are trends or common issues which need

to be addressed systemically.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR § 441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When the DHS/DDS determines an individual may require ICF-IID level of care, the individual or legal representative is informed of any feasible alternatives under the waiver and is given the choice to receive those services in an institution or through an HCBS Waiver. Evidence of this choice is documented initially and annually thereafter using the "Documentation of Consumer Choice" form that is provided to and signed by the individual or legal representative. This form gives the individual the choice between institutional care and HCBS and outlines the freedom to choose from any available provider of waiver services. DHS/DDS Intake Staff inform potential members of the services available through the waiver and routinely provides this information through verbal communication and by providing informational pamphlets to potential members and their legal representatives. The DHS/DDS Case Manager explains, with detail, the process for authorization of waiver services, the Team process and is also responsible for ensuring completion of the "Documentation of Consumer Choice" form. Additionally, OHCA policy, OAC 317:30-3-14, assures that any individual eligible for SoonerCare may obtain services from any institution, agency, pharmacy, person or organization that is qualified to perform the services.

- b. Maintenance of Forms.** Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The DHS/DDS Case Manager maintains these forms and a copy is maintained electronically in the DDS case management database.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The State has entered into a statewide Agreement for interpreter services to include services for Limited English Proficiency (LEP) persons as well as individuals who are deaf.

DHS/DDS employs bilingual Case Managers and DHS forms and pamphlets are available in Spanish.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Habilitation Training Specialist Services		
Statutory Service	Prevocational Services		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Other Service	Environmental Accessibility Adaptations and Architectural Modification		
Other Service	Family Training		
Other Service	Occupational and Physical Therapy		
Other Service	Respite Daily		
Other Service	Self Directed Goods and Services (SD-GS)		
Other Service	Specialized Medical Supplies and Assistive Technology		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Service:

Alternate Service Title (if any):

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

This includes services to support the service member's self care, daily living, adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to a member's independence, self-sufficiency, community inclusion and well-being. Payment does not include room and board or maintenance, upkeep and improvement of the member's or family's residence.

Habilitation Training Specialist (HTS) services are authorized in an acute care hospital, by the 1915(c) HCBS provider, per the CARES Act when the service is:

- (A) identified in the member's person-centered plan of services and supports;
- (B) not duplicative of services available in the acute care hospital setting;
- (C) provided to meet needs of the member that are not met through the provision of hospital services;
- (D) not a substitute for services the hospital is obligated to provide through its conditions of participation or under Federal or State law; (E) designed to ensure smooth transitions between acute care settings and home and community-based settings; and
- (F) when the service will assist the member in preserving function and returning to the community.

The rate for the HTS service is the same regardless of where the service is delivered.

The service must be authorized in the member's plan of care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

☒ Participant-directed as specified in Appendix E

- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by (check each that applies):

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Habilitation Training Specialist
Agency	Habilitation Training Specialist Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Habilitation Training Specialist Services

Provider Category:

Individual

Provider Type:

Habilitation Training Specialist

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Current SoonerCare Provider Agreement with OHCA to provide Habilitation Training Specialist services to OKDHS/DDSD HCBS waiver members.

Providers must complete the DHS/DDS sanctioned training curriculum. Habilitation providers are at least 18 years old, specifically trained to meet the unique needs of the waiver member, successfully complete all required background checks in accordance with 56 O.S. § 1025.2 and receive supervision, guidance and oversight from a contracted agency staff with a minimum of four years of any combination of college level education and/or "full-time equivalent" experience in serving people with disabilities.

Family members who provide HTS services must meet the same standards as providers who are unrelated to the member.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS/DDS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service**Service Name: Habilitation Training Specialist Services****Provider Category:**

Agency

Provider Type:

Habilitation Training Specialist Agency

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Current SoonerCare Provider Agreement with OHCA to provide Habilitation Training Specialist services to OKDHS/DDSD HCBS waiver members.

Providers must complete the DHS/DDS sanctioned training curriculum. Habilitation providers are at least 18 years old, specifically trained to meet the unique needs of the waiver member, successfully complete all required background checks in accordance with 56 O.S. § 1025.2 and receive supervision, guidance and oversight from a contracted agency staff with a minimum of four years of any combination of college level education and/or "full-time equivalent" experience in serving people with disabilities.

Family members who provide HTS services must meet the same standards as providers who are unrelated to the member.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHS/DDS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

04 Day Services

Sub-Category 1:

04010 prevocational services

07/16/2026

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

These services are not available under a program funded under 2014 Workforce Innovation and Opportunity Act (WIOA), Title IV Amendments to the Rehabilitation Act of 1973 or IDEA (20 U.S.C 1401 et seq.). Prevocational services provide learning and work experiences where the individual can develop general, non-job task specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services include teaching such concepts as the ability to communicate effectively with supervisors, attendance, task completion, problem solving, stamina building and workplace safety. Community based opportunities provide work experiences including volunteer work, adult learning and training in a variety of locations in the community.

With prior approval by the Team, this service may be provided remotely. The percentage of time this service is provided via telehealth depends on the needs of the participant as identified and addressed in the Virtual Services Risk Assessment. This service can be provided via telehealth up to 100% of the time the service is delivered. In-person visits will be required when Prevocational services are provided upon request by the participant and as determined by the Team. The telehealth delivery of this service must meet HIPAA requirements and the methodology must be accepted by the state's HIPAA compliance officer. The delivery of this service via telehealth does not allow video cameras or video monitors in bedrooms or bathrooms. In-person face-to-face delivery of services are required for those who need hand-on assistance/physical assistance with specific tasks. The telehealth delivery of services will only be considered for tasks that do not require in-person physical intervention. The State supports participants who need assistance with using the technology required for the telehealth delivery of the service by providing consultation, training and retraining when needed by the participant, the provider, family and others to ensure they know how to use the equipment. The State requires the completion of a Virtual Risk Assessment regarding home and community safety issues, medical support needs and behavioral health support needs to identify the appropriate supports to ensure health and safety. The telehealth delivery of these services is only approved upon Team recommendation and approval by the DDS Division Director or designee.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying, habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the member's Individual Plan (Plan) as reflected in the person centered planning process.

Each provider agency assesses each member in maximizing employment options. Supplemental or enhanced supports provide assistance addressing behavioral needs related to a dangerous behavior or personal care. Assessments are updated and reviewed annually in the member's Team process. It is the responsibility of each provider to ensure services are provided in the most integrated setting appropriate to meet the member's needs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is available to members of transition age.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☒ Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☒ Relative

☒ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Workshops and other Prevocational Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Workshops and other Prevocational Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Current SoonerCare Provider Agreement with OHCA to provide employment services to DHS/DDS HCBS waiver members.

Prevocational service providers must:

- be at least 18 years of age;
- have completed the DHS/DDS sanctioned training curriculum;
- have not been convicted of, pled guilty, or pled nolo contendere to misdemeanor assault and battery or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2; and
- receive supervision and oversight by a person with a minimum of four years of any combination of college level education or full-time equivalent experience in serving persons with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS/DDS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09012 respite, in-home

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Respite Services are provided to service members unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite Services will be provided in the following locations: service member's home or place of residence or approved community site, foster home or Medicaid Certified ICF-IID.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limited to 30 days or 720 hours annually per member, except as approved by the DHS/DDS Director and authorized in the member's Individual Plan.

Respite Care may not be billed simultaneously with Agency Companion and/or Habilitation Training Specialist services.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☒ Relative
- ☒ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Specialized Foster Care
Agency	Group Home
Agency	Respite Care Provider
Agency	Medicaid Certified ICF-ID
Agency	Agency Companion

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

Specialized Foster Care

Provider Qualifications

License (specify):

Certificate (specify):

DHS/DDS certification

Other Standard (specify):

Current SoonerCare Provider Agreement with OHCA to provide Respite to DHS/DDS HCBS waiver members.

Complete the DHS/DDS sanctioned training curriculum. Providers must successfully complete all required background checks in accordance with 56 O.S. § 1025.2, be specifically trained to meet the unique needs of the member, and be at least 18 years of age.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS/DDS

Frequency of Verification:

Background checks verified annually.

Training verified bi-annually, at minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Group Home

Provider Qualifications

License (specify):

Current license by the Oklahoma Department of Human Services per 10 O.S. Supp 2000, 1430.1 et seq.

Certificate (specify):

Other Standard (specify):

Current SoonerCare Provider Agreement with OHCA to provide Respite services to DHS/DDS HCBS waiver members.

Training requirements per OAC 340:100-3-38

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS/DDS

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

Provider Type:

Respite Care Provider

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Current SoonerCare Provider Agreement with OHCA to provide Respite to DHS/DDS HCBS waiver members.

Providers must complete the DHS/DDS sanctioned training curriculum. Providers must successfully complete all required background checks in accordance with 56 O.S. § 1025.2, must be specifically trained to meet the unique needs of members and be at least 18 years of age.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHS/DDS

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**

Agency

Provider Type:

Medicaid Certified ICF-ID

Provider Qualifications**License (specify):**

Current license by the Oklahoma State Department of Health according to Title 63 O.S. Supp. 1998, § 1-1901 et seq.

Certificate (specify):

Medicaid certification by the Oklahoma Health Care Authority

Other Standard (specify):

Enter into a Medicaid agreement with Oklahoma Health Care Authority for this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Health Care Authority

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Agency Companion

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Current SoonerCare Provider Agreement with OHCA to provide Respite to DHS/DDS HCBS waiver members.

Providers must complete the DHS/DDS sanctioned training curriculum. Habilitation providers are at least 18 years old, specifically trained to meet the unique needs of the waiver member, successfully complete all required background checks in accordance with 56 O.S. § 1025.2 and receive supervision, guidance and oversight from a contracted agency staff with a minimum of four years of any combination of college level education and/or "full-time equivalent" experience in serving people with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS/DDS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

07/16/2026

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

03 Supported Employment

Sub-Category 1:

03010 job development

Category 2:

03 Supported Employment

Sub-Category 2:

03021 ongoing supported employment, individual

Category 3:

03 Supported Employment

Sub-Category 3:

03022 ongoing supported employment, group

Category 4:**Sub-Category 4:****Service Definition (Scope):**

Supported employment is conducted in a variety of settings, particularly work sites, in which persons without disabilities are employed. Supported employment includes activities that are outcome based and needed to sustain paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. When supported employment services are provided at a work site in which persons without disabilities are employed, services may include job analysis, adaptations, training and systematic instruction required by members, and will not include payment for the supervisory activities rendered as a normal part of the business setting. Supported employment consists of job development, assessment, benefits planning, supportive assistance and job coaching up to 100% of on-site intervention. Stabilization or ongoing support is available for those requiring less than 20% on-site intervention. Supported employment in an individual placement promotes the member's capacity to secure and maintain integrated employment at a job of the member's choice paying at or more than minimum wage. Supported employment in an individual placement may be provided by a coworker or other job site personnel. The job coach meets qualifications for providers of service.

Stabilization and extended services are ongoing supported employment services needed to support and maintain a member with severe disabilities in an integrated competitive employment site. The service includes regular contacts with the member to determine needs, as well as to offer encouragement and advice. These services are provided when the job coach intervention time required at the job site is 20% or less of the member's total work hours. This service is provided to members who need ongoing intermittent support to maintain employment. Typically this is provided at the work site. Stabilization must identify the supports needed in the member's Individual Plan (Plan) and specify in a measurable manner, the services to be provided to meet the need. Group placement supports in supported employment are two to eight members receiving continuous support in an integrated work site. Services promote participation in paid employment paying at or more than minimum wage or working to achieve minimum wage. Services promote integration into the workplace and interaction with people without disabilities.

The outcome of supported employment is sustained paid employment at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities in an integrated setting in the general workforce, in a job that meets personal and career goals. Supported employment services furnished under the waiver are not available under a program funded by the 2014 Workforce Innovation and Opportunity Act (WIOA), Title IV Amendments to the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). Documentation will be maintained in the file of each member receiving this service that the service is not otherwise available under a program funded through the Rehabilitation Act of 1973, or IDEA (20 U.S.C. 1401 et seq.). Federal Financial Participation (FFP) will not be claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following:

-Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

-Payments that are passed through to users of supported employment programs; or

-Payments for vocational training not directly related to a member's supported employment program.

With prior approval by the Team, this service may be provided remotely. The percentage of time this service is provided via telehealth depends on the needs of the participant as identified and addressed in the Virtual Services Risk Assessment. This service can be provided via telehealth up to 100% of the time the service is delivered. In-person visits will be required when Supported Employment services are provided upon request by the participant and as determined by the Team. The telehealth delivery of this service must meet HIPAA requirements and the methodology must be accepted by the state's HIPAA compliance officer. The delivery of this service via telehealth does not allow video cameras or video monitors in bedrooms or bathrooms. In-person face-to-face delivery of services are required for those who need hand-on assistance/physical assistance with specific tasks. The telehealth delivery of services will only be considered for tasks that do not require in-person physical intervention. The State supports participants who need assistance with using the technology required for the telehealth delivery of the service by providing consultation, training and retraining when needed by the participant, the provider, family and others to ensure they know how to use the equipment. The State requires the completion of a Virtual Risk Assessment regarding home and community safety issues, medical support needs and behavioral health support needs to identify the appropriate supports to ensure health and safety. The telehealth delivery of these services is only approved upon Team recommendation and approval by the DDS Division Director or designee.

Individuals may receive services from the Department of Developmental Disabilities (DDS) if DRS is not able to begin providing supports within 15 days from the date the VR application is completed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is available to members of transition age.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☒ Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☒ Relative
- ☒ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Employment Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Employment Services

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Current SoonerCare Provider Agreement with OHCA to provide Employment Services to DHS/DDS HCBS waiver members.

Providers must complete the DHS/DDS sanctioned training curriculum. Providers must successfully complete all required background checks in accordance with 56 O.S. § 1025.2, be specifically trained to meet the unique needs of the waiver member, be 18 years of age and be supervised by an individual with a minimum of four years of any combination of college level education and/or full-time equivalent experience in serving people with developmental disabilities.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Frequency of Verification:

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:**Sub-Category 4:**

Service Definition (Scope):

Those architectural and environmental modifications and adaptations to the home, required by the member's Plan, which are necessary to ensure the health, welfare and safety of the member or which enable the member to function with greater independence in the home. Such modifications or adaptations include the installation of ramps, grab-bars, widening of doorways, modification of a bathroom or kitchen facilities, specialized safety adaptations such as scald protection devices, stove guards and modifications required for the installation of specialized equipment which are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home. Vehicle adaptations are included in Environmental Accessibility Adaptations and Architectural Modification to ensure safe transfer and greater community involvement of the member.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the member, construction, reconstruction, or remodeling of any existing construction in the home such as floors, sub-floors, foundation work, roof or major plumbing. All services shall be provided in accordance with applicable Federal, State or local building codes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

No more than two different residences modified in a seven year period. Exceptions may be approved by the Division Administrator or designee in extenuating circumstances.

Vehicles must be owned by the member or his or her family. Vehicle modifications are limited to one modification in a ten year period. Requests for more than one vehicle modification per ten years must be approved by the DHS/DDS Division Administrator or designee.

An additional \$22,500.00 combined service limit is allowed, as described in Appendix B-2:c.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Building Contractor

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations and Architectural Modification

Provider Category:

Individual

Provider Type:

Building Contractor

Provider Qualifications

License (specify):

Certificate (specify):**Other Standard (specify):**

Current SoonerCare Provider Agreement with the Oklahoma Health Care Authority to provide Architectural Modification services to DHS/DDS HCBS waiver members.

Provider must meet International Code Council (ICC) requirements for building, electrical, plumbing and mechanical inspections. All providers must meet applicable state and local requirements and provide evidence of liability insurance, vehicle insurance and worker's compensation insurance or affidavit of exemption.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Oklahoma Department of Central Services and DHS/DDS

Frequency of Verification:

Ongoing through the authorization process

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Training

HCBS Taxonomy:**Category 1:**

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training

Category 2:

10 Other Mental Health and Behavioral Services

Sub-Category 2:

10030 crisis intervention

Category 3:

10 Other Mental Health and Behavioral Services

Sub-Category 3:

10060 counseling

Category 4:**Sub-Category 4:****Service Definition (Scope):**

Family Training services include instruction in skills and knowledge pertaining to the support and assistance of members. Services are intended to allow families to become more proficient in meeting the needs of members; provided in any

community setting; provided in either group or individual formats; for members served through an DHS/DDS HCBS waiver and their families. For the purpose of this service, family is defined as any person who lives with or provides care to a member served on the waiver; included in the member's Individual Plan (Plan) and arranged through the member's Case Manager; and intended to yield outcomes as defined in the member's Plan.

Family Training services may be provided per DHS/DDS telehealth rules when appropriate. The telehealth delivery option must be of the same quality and otherwise on par with the same service delivered in person. Family Training services utilizing the telehealth delivery option are not an expansion of Family Training services.

When telehealth is utilized to deliver Family Training services, HIPAA requirements are followed and methodology is approved by Oklahoma's HIPAA compliance officer. Only secure, non-public facing platforms are used for telehealth services. The telehealth service delivery method is only used when the member has provided consent, is comfortable, available, and both the provider and member are in locations that protects the member's privacy. In general, the use of cameras in bathrooms or bedrooms is not permitted. If a unique health and safety situation necessitated the need for cameras in a bathroom or bedroom, beyond a fall sensor, the overseeing Statewide Human Rights and Behavior Review Committee would be required to authorize the plan and would ensure rights and privacy were in accordance with the person-centered service plan.

Telehealth supports community integration by allowing members to receive services in their homes, responding to member needs quickly, eliminating transportation barriers as well as limiting exposure to others with health concerns. Telehealth providers will ensure member health and safety by contacting a member's caregiver in the event a health or safety issue becomes evident during a telehealth session.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The cost of Family Training services may not exceed \$6500.00 per the member's plan of care year for individual Family Training services and \$6500.00 per the member's plan of care year for Family Training group services. Members may be authorized for Family Training services on an individual basis, as part of a group or they may receive a combination of group and individual training services. The total cost of both individual Family Training and group Family Training may not exceed \$13,000.00 per the member's plan of care year. The Case Manager assists the member to identify other alternatives to meet identified needs above the limit.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☒ Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Family Training Agency or Business
Individual	Qualified Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Family Training

Provider Category:

Agency

Provider Type:

Family Training Agency or Business

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Current SoonerCare Provider Agreement with the Oklahoma Health Care Authority to provide Family Training to DHS/DDS HCBS waiver members.

DHS/DDS Family Training provider application and training curriculum approved by DHS/DDS.

Provider must have current license, certification or a Bachelors Degree in a human service field related to the DHS/DDS approved Family Training curriculum.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHS/DDS

Frequency of Verification:

Ongoing

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Family Training****Provider Category:**

Individual

Provider Type:

Qualified Individual

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Current SoonerCare Provider Agreement with Oklahoma Health Care Authority to provide Family Training to DHS/DDS HCBS waiver members.

Current license, certification or Bachelors Degree in a human service field related to DHS/DDS approved curriculum.

DHS/DDS Family Training application and training curriculum approved by DHS/DDS.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHS/DDS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

HCBS Taxonomy:
Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Assessment service for the purpose of architectural modification specific to the member's need for architectural or home modifications. This service is an on-site assessment of the member's home that is not included in most routine Occupational Therapy (OT) or Physical Therapy (PT) evaluations. If the existing OT or PT evaluation or assessment includes architectural modification needs and assessment, a second home/architectural modification assessment would not be required or authorized. These assessments address modifications such as roll-in showers, door widening, modification of kitchens, etc.

Therapy services are not available through this waiver and should be accessed under provisions of the Medicaid State Plan EPSDT.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person

☐ Relative

☐ Legal Guardian
Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist
Individual	Physical Therapist
Agency	Physical Therapist
Agency	Occupational Therapists

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Occupational and Physical Therapy****Provider Category:**

Individual

Provider Type:

Occupational Therapist

Provider Qualifications**License (specify):**

Non-restrictive licensure by the Oklahoma State Board of Medical Licensure and Supervision as an Occupational Therapist, 59 O.S. Supp 2000, Section 888.1. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure to practice Occupational Therapy in the adjacent state.

Certificate (specify):**Other Standard (specify):**

Current SoonerCare Provider Agreement with the Oklahoma Health Care Authority to provide Occupational Therapy services to DHS/DDS HCBS waiver members

Current SoonerCare General Provider Agreement - Special Provisions for Occupational Therapists, with Oklahoma Health Care Authority

Verification of Provider Qualifications**Entity Responsible for Verification:**

Oklahoma Health Care Authority

Frequency of Verification:

Ongoing through the claims process

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Occupational and Physical Therapy****Provider Category:**

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License (specify):

Non-restrictive licensure as a Physical Therapist with the Oklahoma State Board of Medical Licensure and Supervision, 59 O.S. Supp 2000, Section 887. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure to practice Physical Therapy in the adjacent state.

Certificate (specify):**Other Standard (specify):**

Current SoonerCare Provider Agreement with the Oklahoma Health Care Authority to provide Physical Therapy services to DHS/DDS HCBS waiver members.

Current SoonerCare General Provider Agreement - Special Provisions for Physical Therapists, with Oklahoma Health Care Authority

Verification of Provider Qualifications**Entity Responsible for Verification:**

Oklahoma Health Care Authority

Frequency of Verification:

Ongoing through the claims process

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Occupational and Physical Therapy****Provider Category:**

Agency

Provider Type:

Physical Therapist

Provider Qualifications**License (specify):**

Non-restrictive licensure as a Physical Therapist with the Oklahoma State Board of Medical Licensure and Supervision, 59 O.S. Supp 2000, Section 887. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure to practice Physical Therapy in the adjacent state.

Certificate (specify):**Other Standard (specify):**

Current SoonerCare Provider Agreement with the Oklahoma Health Care Authority to provide Physical Therapy services to DHS/DDS HCBS waiver members.

Current SoonerCare General Provider Agreement - Special Provisions for Physical Therapists, with Oklahoma Health Care Authority

Verification of Provider Qualifications**Entity Responsible for Verification:**

Oklahoma Health Care Authority

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Occupational and Physical Therapy

Provider Category:

Agency

Provider Type:

Occupational Therapists

Provider Qualifications

License (specify):

Non-restrictive licensure by the Oklahoma State Board of Medical Licensure and Supervision as an Occupational Therapist, 59 O.S. Supp 2000, Section 888.1. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure to practice Occupational Therapy in the adjacent state.

Certificate (specify):

Other Standard (specify):

Current SoonerCare Provider Agreement with the Oklahoma Health Care Authority to provide Occupational Therapy services to DHS/DDS HCBS waiver members.

Current SoonerCare General Provider Agreement - Special Provisions for Occupational Therapists, with Oklahoma Health Care Authority

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Health Care Authority

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Respite Daily

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

07/16/2026

Category 2:

09 Caregiver Support

Sub-Category 2:

09012 respite, in-home

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Daily service provided to members unable to care for themselves and furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite Daily service is provided in the following locations: approved community site, group home, Agency Companion home, Specialized Foster Care home or Medicaid certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Respite care:

- is not available to members in the custody of the Department of Human Services (DHS) and in an out-of home placement funded by DHS Children and Family Services; and
- is limited to 30 days or 720 hours annually per member, except as approved by the DDS/DDS Director and authorized in the member's Individual Plan.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☒ Relative
- ☒ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Respite Care Provider
Individual	Respite Care Provider
Individual	Specialized Foster Care
Agency	Agency Companion

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Respite Daily

Provider Category:

Agency

Provider Type:

Respite Care Provider

07/16/2026

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Current SoonerCare Provider Agreement with OHCA to provide Respite to DHS/DDS HCBS waiver members.

Providers must complete the DHS/DDS sanctioned training curriculum. Providers must successfully complete all required background checks in accordance with 56 O.S. § 1025.2, must be specifically trained to meet the unique needs of members and be at least 18 years of age.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHS/DDS

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Respite Daily****Provider Category:**

Individual

Provider Type:

Respite Care Provider

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Current SoonerCare Provider Agreement with OHCA to provide Respite to DHS/DDS HCBS waiver members.

Providers must complete the DHS/DDS sanctioned training curriculum. Providers must successfully complete all required background checks in accordance with 56 O.S. § 1025.2, must be specifically trained to meet the unique needs of members and be at least 18 years of age.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHS/DDS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Respite Daily

Provider Category:

Individual

Provider Type:

Specialized Foster Care

Provider Qualifications

License (specify):

Certificate (specify):

DHS/DDS Certification

Other Standard (specify):

Current SoonerCare Provider Agreement with OHCA to provide Respite to DHS/DDS HCBS waiver members.

Complete the DHS/DDS sanctioned training curriculum. Providers must successfully complete all required background checks in accordance with 56 O.S. § 1025.2, be specifically trained to meet the unique needs of the member, and be at least 18 years of age.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS/DDS

Frequency of Verification:

Background checks verified annually.

Training verified bi-annually, at minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Respite Daily

Provider Category:

Agency

Provider Type:

Agency Companion

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Current SoonerCare Provider Agreement with OHCA to provide Respite to DHS/DDS HCBS waiver members.

Providers must complete the DHS/DDS sanctioned training curriculum. Providers must be at least 18 years of age, specifically trained to meet the unique needs of the member, successfully complete all required background checks in accordance with 56 O.S. § 1025.2 and receive supervision, guidance and oversight from a contracted agency staff member with a combination of four years of college level education and/or full-time equivalent experience in serving people with

disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS/DDS

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Self Directed Goods and Services (SD-GS)

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Self Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care. These goods and services are purchased from the self directed budget. Goods or services must meet the following requirements:

- The item or service is designed to meet the member's functional, social or medical needs, advance the desired outcome of the Self Directed Services Support Plan and is included in the member's plan of care.
- The item or service is justified by a recommendation from a licensed professional and is approved on the plan of care.
- The item or service is not prohibited by Federal and State statutes and regulations.

- One or more of the following additional criteria are met:
 - * the item or service would increase the member's functioning related to the disability;
 - * the item or service would increase the member's safety in the home environment; or
 - * the item or service would decrease dependence on other Medicaid-funded services.
- The item or service is not available through Medicaid State Plan services or another source.
- The service does not include experimental goods and services.
- Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of Federal Financial Participation (FFP) for waiver services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by (check each that applies):

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Business or provider registered with the Secretary of State

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Self Directed Goods and Services (SD-GS)

Provider Category:

Individual

Provider Type:

Business or provider registered with the Secretary of State

Provider Qualifications

License (specify):

Not required

Certificate (specify):

Not required

Other Standard (specify):

Business or provider must be registered with the Secretary of State, and in good standing in the state that offers the approved goods or services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Member / Confirmed by Financial Management Service (FMS)

Frequency of Verification:

Upon purchase and annually at planning meeting

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Supplies and Assistive Technology

HCBS Taxonomy:**Category 1:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

14032 supplies

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14031 equipment and technology

Category 3:**Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

Specialized Medical Supplies include supplies specified in the plan of care which enable members to increase their abilities to perform activities of daily living. This service also includes the purchase of ancillary supplies not available under SoonerCare. Items reimbursed with HCBS waiver funds are in addition to any supplies furnished under SoonerCare and exclude those items which are not of direct medical or remedial benefit to the member. All items meet applicable standards of manufacture, design and installation.

Supplies include the following:

- nutritional supplements;
- supplies needed for health conditions;
- supplies for respirator/ventilator care;
- supplies for decubitus care;
- supplies for catheterization.

Specialized Medical Supplies are available to children through the waiver above and beyond that which is covered by SoonerCare, EPSDT. Specialized Medical Supplies available to children through the waiver include nutritional supplements in certain cases.

Assistive Technology includes devices, controls and appliances specified in the member's Individual Plan (Plan) which enable members to increase their abilities to perform activities of daily living or to perceive, control or communicate with the environment in which they live. This service also includes the purchase or limited rental of items necessary for life support and equipment necessary to the proper functioning of such items including durable and non-durable medical equipment not available under SoonerCare. Items reimbursed with HCBS waiver funds are in addition to any medical equipment and supplies furnished under SoonerCare and exclude those items that are not of direct medical or remedial benefit to the member. All items must meet applicable standards of manufacture, design and installation. All devices identified in the Oklahoma Elevator Safety Law must comply with OAC 380:70. Services include fees associated with installation, labor, inspection and operation. Internet service fees are not included in the cost for any services.

Assistive Technology services include:

- assessment for the need of assistive technology/auxiliary aids;
- training the member/provider in the use and maintenance of equipment/auxiliary aids;
- repair of adaptive devices.

Equipment provided includes:

Devices for the protection of health and safety of members who are blind or visually impaired or deaf or hard of hearing;

Mobility and position devices including wheelchairs, lifts, specialized beds, wedges, bed rail padding, specialized car seats, adapted strollers, therapeutic indoor swings;

Orthotics and prosthetic devices including braces, prescribed modified shoes, splints, hearing aids;

Environmental control devices;

Items necessary for life support, and devices necessary for the proper functioning of such items, including durable and non-durable medical equipment not available through SoonerCare (Medicaid);

Sensors (including motion, bed, chair, door, window, pressure sensors in mats or for floors);

Automated medication dispenser systems;

Software applications to increase independence;

Computers, smart watches, and tablets;

Smoke alarms, carbon monoxide detectors;

Stove guards or oven shut off systems;

Personal Emergency Response Systems or mobile;

Emergency Response Systems;

Global positioning system monitoring devices;

Radio frequency identification;

Cameras without audio capabilities.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

An additional \$22,500.00 combined service limit is allowed, as described in Appendix B-2:c.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Durable Medical Equipment and/or Medical Supplies Dealer
Agency	Durable Medical Equipment and/or Medical Supplies Dealer

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Medical Supplies and Assistive Technology

Provider Category:

Individual

Provider Type:

Durable Medical Equipment and/or Medical Supplies Dealer

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Current SoonerCare Provider Agreement with the Oklahoma Health Care Authority to provide Durable Medical Equipment and/or Specialized Medical Supplies and comply with all applicable State and Federal laws.

Company, corporation or individual must have registered their intention to do business in the state of Oklahoma with the Secretary of State.

Provider guarantees equipment, work and materials for one year and supplies necessary follow-up evaluation to ensure optimum usability. Provider ensures a licensed Occupational Therapist, Physical Therapist, Speech/Language Pathologist or Rehabilitation Engineer evaluates need and individually customizes any equipment as needed.

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Health Care Authority

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Supplies and Assistive Technology

Provider Category:

Provider Type:

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Current SoonerCare Provider Agreement with the Oklahoma Health Care Authority to provide Durable Medical Equipment and/or Specialized Medical Supplies and comply with all applicable State and Federal laws.

Company, corporation or individual must have registered their intention to do business in the state of Oklahoma with the Secretary of State.

Provider guarantees equipment, work and materials for one year and supplies necessary follow-up evaluation to ensure optimum usability. Provider ensures a licensed Occupational Therapist, Physical Therapist, Speech/Language Pathologist or Rehabilitation Engineer evaluates need and individually customizes any equipment as needed.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Frequency of Verification:

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ☐ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ☒ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☒ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

The Oklahoma Department of Human Services Developmental Disabilities Services (DHS/DDS), the operating agency, conducts case management functions on behalf of waiver service members.

All Case Managers complete training for the HCBS settings criteria via the online training platform. Case Managers also complete training on person-centered service planning, including Person-Centered Thinking; Person-Centered Assessment; requirements for identifying person-centered outcomes; and every section of the DDS person-centered service plan (the Individual Plan or the Plan) templates.

In addition, quarterly refresher trainings are provided to address any trends that arise with the person-centered service plan and/or the person-centered service plan development process.

- d. Remote/Telehealth Delivery of Waiver Services.** Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Prevocational Services
Supported Employment
Family Training

1. Will any in-person visits be required?

- ☒ **Yes.**
☐ **No.**

2. By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.

- ☒ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Explain:**

The delivery of the prevocational service and the supported employment service via telehealth does not allow video cameras or video monitors in bedrooms or bathrooms.

In general, the use of cameras in bathrooms or bedrooms is not permitted for telehealth delivery of the Family Training service. If a unique health and safety situation necessitated the need for cameras in a bathroom or bedroom, beyond a fall sensor, the overseeing Statewide Human Rights and Behavior Review Committee would be required to authorize the plan and would ensure rights and privacy were in accordance with the person-centered service plan.

- ☒ **How the telehealth service delivery will facilitate community integration. Explain:**

Telehealth delivery of the prevocational and supported employment services supports community integration by allowing members more independence while in the community without the physical presence of a paid support.

Telehealth delivery of the Family Training service supports community integration by allowing members to receive services in their homes, responding to member needs quickly, eliminating transportation barriers as well as limiting exposure to others with health concerns.

- ☒ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual. *Explain:***

In-person face-to-face delivery of services are required for those who need hands-on assistance/physical assistance with specific tasks. The telehealth delivery of services will only be considered for tasks that do not require in-person physical intervention.

- ☒ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service. *Explain:***

The State supports participants who need assistance with using the technology required for the telehealth delivery of the service by providing consultation, training and retraining when needed by the participant, the provider, family and others to ensure they know how to use the equipment.

- ☒ **How the telehealth will ensure the health and safety of an individual. *Explain:***

The State requires the completion of a Virtual Risk Assessment regarding home and community safety issues, medical support needs and behavioral health support needs to identify the appropriate supports to ensure health and safety during the telehealth delivery of the prevocational and supported employment services. The telehealth delivery of these services is only approved upon Team recommendation and approval by the DDS Division Director or designee.

Telehealth providers will ensure member health and safety by contacting a member's caregiver in the event a health or safety issue becomes evident during a telehealth session.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ☐ **No. Criminal history and/or background investigations are not required.**
- ☒ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) A criminal history record search is required by statute and policy prior to an offer to employ a community services worker. (Title 56 OS Sec. 1025.1 et seq.: OAC 340:100-3-39). Any potential employee or volunteer who is not a licensed health professional, including supervisory, management or administrative positions, if the applicant is to provide, on a full time or part time basis, supportive assistance, health related services or training to a person(s) with developmental disabilities or intellectual disability. (b) Each provider requests a statewide criminal records check from the Oklahoma State Bureau of Investigation (OSBI) which the employer is required or authorized to request pursuant to the provisions of this section. (c) DDS Quality Assurance Unit annually reviews a sample of the records of each provider to assure that the required documentation is on file for all applicable employees.

All applicants for licensure or renewal of licensure as a health professional in Oklahoma must report arrests, criminal charges, and disciplinary acts on any health-related license or certificate. The applicable licensing Board, such as the Oklahoma Board of Nursing or the Oklahoma Medical Board, enforces licensing rules, monitors for accuracy of information submitted for licensure or renewal of licensure, and performs investigations and provides disciplinary actions to licensed health professionals per applicable Oklahoma practice acts.

Agencies contracted to provide professional health services to DDS waiver members are required to perform criminal background checks with the Oklahoma State Bureau of Investigation (OSBI) as part of the employment screening for licensed staff employed by that agency.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ☐ **No. The state does not conduct abuse registry screening.**
- ☒ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The abuse registry is maintained by the DHS; (b) any potential employee or volunteer who is not a licensed health professional, including supervisory, management or administrative positions, if the applicant is to provide, on a full time or part time basis, supportive assistance, health-related services or training to a person(s) with developmental disabilities or intellectual disability, must receive a community services registry check as required by statute and policy prior to an offer to employ. (Title 56 OS Sec. 1025.1 et seq.: OAC 340:100-3-39); (c) provider agencies are required to conduct the pre-employment registry check. Quality Assurance Unit annually reviews a sample of the records of each provider to assure that the required documentation is on file for all applicable employees; (d) provider agencies ensure adequate staff is available to meet the needs of any members who are impacted by a service provider added to the abuse registry.

Section 1025.1 et seq. or Title 56 of the Oklahoma Statutes requires Oklahoma Department of Human Services (DHS) to establish and maintain a registry listing the names of community services workers against whom a final investigative finding of maltreatment involving a member, has been made by DHS or an administrative law judge. Requirements contained in statute and in administrative regulations apply to all community services providers who contract with, or are licensed or funded by DHS or who contract with Oklahoma Health Care Authority (OHCA) to provide residential or employment services to members through DHS/DDS HCBS waivers. Community services workers include persons who have entered into Agreements with OHCA to provide specialized foster care, habilitation training specialist services, or homemaker services to persons with developmental disabilities as well as persons employed by or under contract with a community services provider to provide HCBS waiver services. Licensed health professional are regulated by their respective licensing boards and are not subject to inclusion on the community services worker registry.

DHS is the investigative authority for allegations of maltreatment involving vulnerable adults. In addition to sending investigation reports to the appropriate District Attorney, reports in which a confirmation of maltreatment (as defined in state statute) is made against a licensed health professional are sent to the licensed professionals respective licensure Board.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one:*

- ☐ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ☒ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar

services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Payment may be made to parents of minor children and spouses to provide traditional or self-directed Habilitation Training Specialist (HTS) services. Unless otherwise specified, all references to 'parents' include biological parents, adoptive parents, step-parents, foster parents, legal guardians of minors, and others who are legally responsible individuals. Parents whose parental rights of the waiver member have been terminated cannot be paid to provide care to the waiver member. Parents of the waiver member who has been taken into state custody cannot be paid to provide care to the waiver member.

Payment will be made to legally responsible individuals to provide HTS service determined extraordinary per OAC 340:100-3-33.2. Extraordinary care is care that exceeds the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age and which is necessary to assure the health and welfare of the participant and avoid institutionalization. The Oklahoma Choice assessment is the State's method for determining that the amount of HTS provided by a legally responsible individual is extraordinary care. The Oklahoma Choice assessment provides a means to identify activities in which the participant is dependent, to distinguish between activities that a parent or family member would ordinarily perform and those activities that go beyond what is normally expected to be performed, and to identify areas in which the level of assistance or supervision required exceeds what is typically required of a person of the same age. The Oklahoma Choice assessment is a comprehensive, broad assessment that looks at ADL dependencies across several program areas. Any ADL dependency documented in the Oklahoma Choice assessment, which meets the eligibility criteria for any program, is valid for determining the ADL dependency requirement for paying a spouse or parent of a minor for HTS services.

The service must:

- meet the HTS service definition and criteria for allowable expenditures, as outlined in the approved waiver;
- be a service/support that is specified in the participant's support plan;
- be provided by a parent or spouse who meets the provider qualifications for the HTS service and are identified as necessary in the participant's support plan;
- be related to the participant's disability and NOT be an activity that a parent of a minor or spouse would ordinarily perform or is responsible to perform; and
- be necessary to meet at least one identified dependency in activities of daily living (ADL), which is determined based on the ADL items included in the assessment the person receives.

In addition to the above:

- the amount of service is limited to the overall number of hours established in the participant's Plan. Parents (as defined above) of minor children and spouses may not receive payment for more than 40 hours per week of service in a seven-day period. For parents of minor children and spouses, 40 hours is the total amount paid per family regardless of the number of parents, combination of parent(s) of minors and spouse, or number of children who receive HTS. On an ongoing basis, the participant's Team will verify that services provided are appropriate and furnished in the best interest of the participant. A review of the participant's plan of care is completed, at least annually, to ensure services continue to meet the needs of the participant;
- the parents of minors and spouses must maintain and submit time sheets and other required documentation for hours worked and covered by the waiver;
- parents of minors and spouses may only be paid for providing supports that fall within the HTS service.

The State ensures that the provision of services by a legally responsible individual is in the best interest of the participant using the Person-Centered Planning Approach (per Appendix D-1:c). The following criteria must be met and documented in the participant's Plan: 1. Choice of the legally responsible person to provide waiver services truly reflects the participant's wishes and desires; 2. The provision of services by the legally responsible person is in the best interests of the participant and his or her family; 3. The provision of services by the legally responsible person is appropriate and based on the participant's identified support needs; 4. The services provided by the legally

responsible person will increase the participant's independence and community integration; 5. There are documented steps in the Plan that will be taken to expand the participant's circle of support so that he or she is able to maintain and improve his or her health, safety, independence, and level of community integration on an ongoing basis should the legally responsible person acting in the capacity of employee no longer be available; 6. The legally responsible person must sign a service agreement to provide assurances to the State that he or she will implement the Plan and provide the service in accordance with applicable federal and State laws and regulations governing the program.

Payment for all waiver services rendered are approved by prior authorization and are reviewed for post authorization review as outlined in the plan of care per the Quality Improvement Strategy processes. DHS/DDS Quality Assurance Unit monitors the provision of service by conducting annual performance reviews of DHS/DDS member records to ensure member services are provided in an amount, duration and frequency which supports member Plans. OHCA representatives are provided summary reports to review quality indicators on a regular basis. Follow-ups are sent to OHCA as they are completed. OHCA monitors waiver expenditures monthly using data in the MMIS (per Appendix A:2.b.). DHS/DDS monitors non-licensed providers for compliance and provides results to OHCA. OHCA is notified when Administrative Inquiries and follow-ups as well as annual performance reviews and follow-ups are completed.

The following additional requirement applies to participants electing to employ parents of minors, legal guardians, or a spouse for HTS services:

- monthly reviews by the provider agency, or by the provider of financial management services, of hours billed for care provided by legally responsible individuals during the month.

When appropriate, the Case Manager asks the waiver participant and/or others who are knowledgeable about the participant's preferences to verify that any legally responsible individual or non-legally responsible person who has decision-making authority over the selection of waiver service providers uses substituted judgement on behalf of the participant. Otherwise, the Case Manager reviews the importance of using substituted judgement on behalf of the participant with any legally responsible individual or non-legally responsible individual who has decision-making authority over the selection of waiver service providers.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- ☐ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ☒ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians who are not legally responsible for the member may be paid providers of waiver services. Any non-legally responsible relative/legal guardian who serves as paid provider must be qualified to provide the service and meet licensure/certification requirements. Non-legally responsible relatives/legal guardians are subject to the same service limits as any other provider of the same service. The term non-legally responsible relative includes a brother, sister, aunt, uncle, cousin, or grandparent, including those of in-law and step relationship.

Provider agencies may hire non-legally responsible relatives/legal guardians to provide waiver services when the non-legally responsible relative/legal guardian is qualified to provide the service per OAC 340:100-3-33.2. Provider agencies must provide supervision and oversight of employees and ensure that claims are submitted only for services rendered. Members participating in self direction provide supervision and oversight of employees and ensure that claims are submitted only for services rendered. The Financial Management Service (FMS) subagent ensures that claims are submitted only for services authorized in the self directed plan of care.

The State ensures that the provision of services by a non-legally responsible individual is in the best interest of the participant using the Person-Centered Planning Approach (per Appendix D-1:c). The following criteria must be met and documented in the participant's Plan: 1. Choice of the non-legally responsible person to provide waiver services truly reflects the participant's wishes and desires; 2. The provision of services by the non-legally responsible person is in the best interests of the participant and his or her family; 3. The provision of services by the non-legally responsible person is appropriate and based on the participant's identified support needs; 4. The services provided by the non-legally responsible person will increase the participant's independence and community integration; 5. There are documented steps in the Plan that will be taken to expand the participant's circle of support so that he or she is able to maintain and improve his or her health, safety, independence, and level of community integration on an ongoing basis should the non-legally responsible person acting in the capacity of employee no longer be available; 6. The non-legally responsible person must sign a service agreement to provide assurances to the State that he or she will implement the Plan and provide the service in accordance with applicable federal and State laws and regulations governing the program.

Relatives/legal guardians may provide services to include: Respite, Habilitation Training Specialist, Self Directed Habilitation Training Specialist, Prevocational, and Supported Employment services.

The OHCA is responsible for Surveillance and Utilization Review (SUR). The OHCA Provider Audits Unit conducts ongoing monitoring of services to ensure Medicaid guidelines are followed. Any indication that Medicaid guidelines are not being met leads to an investigation that may result in recoupment of payments made to the provider. On a regular basis, DHS/DDS compares a file of paid claims provided by OHCA to services authorized on plans of care to determine if services are being used as authorized. Discrepancy reports are prepared for review and necessary action taken. DHS/DDS Quality Assurance Unit (QA) is involved in a continuous process for review and oversight of waiver participation and services. Quality Assurance Performance Reviews are conducted annually and written summaries are prepared informing the contracted provider agency of any deficiency. DHS/DDS Case Management provides additional oversight and review. Case Managers act as the lead person in monitoring the plan of care through quarterly contacts that result in appropriate follow-up action.

All claims are processed through the Medicaid Management Information System (MMIS) and are subject to post-payment validation. When problems with service validation are identified on a post-payment review, erroneous or invalidated claims are voided from the claims payment system and the previous payment recouped from the provider.

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

Through OHCA's website, providers have ready access to information requirements and procedures to qualify, and the timeframes established for qualifying and enrolling in the program. OHCA provides for continuous, open enrollment of waiver service providers. To participate in SoonerCare, providers must have an agreement on file with the OHCA. The OHCA Provider Enrollment Unit is responsible for validating that any provider meets all of the requirements of participation. The rules applicable to these provisions are found at 317:30-2 and 317:10-1-19. Providers interested in becoming a SoonerCare provider may request a SoonerCare enrollment packet by downloading the required forms, contacting Provider Enrollment by phone, or sending a request in writing by mail to OHCA. DHS/DDS staff assists potential providers by providing applications, and technical assistance, reviewing information to assure the provider qualifications are met and submitting them to OHCA for processing. Once a provider agreement is approved, the agreement remains in effect until the expiration date indicated on the agreement. In the absence of a Notice of Termination by either party, the agreement is renewed every three years as cited in the renewal section of the contract. Whenever a change of ownership occurs, a new provider agreement must be signed. After reviewing the application, certification criteria, and verifying appropriate licensure, certification, etc., OHCA assigns a 10-digit provider number to the new provider. Providers receive written notification of their provider number and the agreement certification effective and expiration date. The provider also receives a PIN letter informing the provider of their PIN to access the OHCA secure website. DXC Technology, the MMIS support vendor, mails out a welcome packet and contacts the provider within ten working days to offer training. Renewal notices are sent to each provider 75 days prior to the expiration date of their contract. A reminder is sent 45 days prior for those that have not been updated. If the renewal is not returned to OHCA, no payments for dates of service after the agreement expiration date are made.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

- ☐ **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ☒ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. By checking the boxes below, the state assures:**
 - ☒ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
 - ☒ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
 - ☒ **The HCBS must be identified in the individual's person-centered service plan; and**
 - ☒ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

And specify: (a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting; (b) How the 1915(c) HCBS will assist the individual in returning to the community; and (c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

Habilitation Training Specialist (HTS) services are authorized in an acute care hospital, by the 1915(c) HCBS provider. When provided in an acute care setting, the service will assist the participant in returning to the community by ensuring continuity of care and allowing effective communication for optimal treatment and preserving function to be able to return home.

The rate for the Habilitation Training Specialist service is the same regardless of where the service is delivered.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. *Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of providers who continue to meet required licensure/certification standards and adhere to other standards prior to furnishing waiver services. Numerator: Number of providers who continue to meet required licensure/certification standards and adhere to other standards prior to furnishing waiver services. Denominator: Total number of licensed/certified providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Oklahoma Board of Medical Licensure and Supervision

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☒ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =

☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☒ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of new providers who meet required licensure/certification standards and adhere to other standards prior to service provision. Numerator: Number of new providers who meet required licensure/certification standards and adhere to other standards prior to service provision. Denominator: Total number of new licensed/certified providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Oklahoma Board of Medical Licensure and Supervision

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

b. Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of direct support agency providers providing required supervision, guidance and oversight of paraprofessional staff providing direct service.

Numerator: Number of direct support agency providers providing required supervision, guidance and oversight of paraprofessional staff providing direct service.

Denominator: Total number of direct support agency providers.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence

		Interval =
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of direct support agency providers whose direct support staff had timely criminal background checks. Numerator: Number of direct support agency providers whose direct support staff had timely criminal background checks. Denominator: Total number of direct support agency providers.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of non-licensed/non-certified providers, who initially and continually meet waiver provider qualifications and adhere to all waiver requirements. Numerator: Number of non-licensed/non-certified providers who initially and continually meet waiver provider qualifications and adhere to all waiver requirements. Denominator: Total number of non-licensed/non-certified providers.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:

	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of direct support agency providers whose direct support staff had timely registry checks. Numerator: Number of direct support agency providers whose direct support staff had timely registry checks. Denominator: Total number of direct support agency providers.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☒ Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

and percent of direct support agency providers who meet basic training requirements in accordance with state requirements and the approved waiver as verified by training verification records. N: # of direct support agency providers who meet basic training requirements in accordance with state requirements and the approved waiver as verified by training verification records. Main B Optional

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =

☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

and percent of direct support agency providers meeting annual training requirements (12 hours) as verified by training records in accordance with state

requirements and the approved waiver. N: Number of direct support agency providers meeting annual training requirements (12 hours) as verified by training records in accordance with state requirements and the approved waiver. Main B Optional

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

An annual survey is completed for each provider agency. Each citation is followed up individually and a resurvey with a new sample is completed to ensure the provider agency does not have systemic issues. All citations must be remediated and if they are not within 60 days, the Performance Review Committee will review the citations and determine if sanctions against the agency are necessary. Quality Assurance staff continue to follow-up until deficiencies are corrected. If issues appear to be systemic, agencies are requested to take advantage of training that is made available through DDS. If, after sanctions and follow-up, a provider remains non-compliant, DHS/DDS recommends Agreement termination action to OHCA.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

☒ **Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

☐ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- ☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are received. *(Specify and describe the types of settings in which waiver services are received.)*

The settings in which 1915(c) HCBS are provided in this waiver are all non-residential, such as a family home or relative home.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

The State assures that all waiver settings meet current and future federal HCB Setting requirements as outlined in the approved Statewide Transition Plan. The Case Manager completes an annual Settings Assessment for each waiver participant to ensure compliance and provide technical assistance when necessary. The Case Manager also makes face-to-face monitoring visits to ensure compliance and address any possible settings that do not comport with requirements. DDS Quality Assurance (QA) staff conducts an annual on-site performance survey with all agencies providing services through this waiver to assess compliance with all relevant rules and policies. The survey includes an evaluation of information obtained from observations, interviews with both members and providers, and a records review. Each on-site visit evaluates the criteria of each of the HCB settings requirements. Provider agencies are given two weeks after the survey exit conference to send a written response to QA to identify a date by which the provider will comply with cited requirements. Any identified contract or policy deficiencies requires a focused resurvey to include a new random sample. Resurveys are completed until all contract and policy requirements are met. The Performance Review Committee makes recommendations for additional action, including relocation of the member to a different provider and provider contract termination, if settings requirements are not met. DDS QA also conducts an area survey to further validate the performance survey and to further evaluate compliance with person-centered service planning.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

- ☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in**

community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

- ☒ The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-1-d-ii)
- ☒ Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- ☒ Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- ☒ Facilitates individual choice regarding services and supports, and who provides them.
- ☒ Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (Specify whether the waiver includes provider-owned or controlled settings.)

- ☒ No, the waiver does not include provider-owned or controlled settings.
- ☒ Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, in addition to meeting the above requirements, will meet the following additional conditions):
 - ☐ The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
 - ☐ Each individual has privacy in their sleeping or living unit:
 - ☐ Units have entrance doors lockable by the individual.
 - ☐ Only appropriate staff have keys to unit entrance doors.
 - ☐ Individuals sharing units have a choice of roommates in that setting.
 - ☐ Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
 - ☐ Individuals have the freedom and support to control their own schedules and activities.
 - ☐ Individuals have access to food at any time.
 - ☐ Individuals are able to have visitors of their choosing at any time.
 - ☐ The setting is physically accessible to the individual.
 - ☐ Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan(see Appendix D-1-d-ii of this waiver application).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individual Support Plan (Plan)

- a. Responsibility for Service Plan Development.** Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the

HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Requirements for a Case Manager consist of a bachelor's Degree in any field and one year of experience working directly with persons with intellectual disabilities or other developmental disabilities or in social work, case management, special education, psychology, counseling, vocational rehabilitation, physical therapy, occupational therapy, speech therapy, nursing or a closely related field; or possession of a valid permanent Oklahoma license as approved by the Oklahoma Board of Nursing to practice nursing and one year working directly with persons with intellectual disabilities or other developmental disabilities. Years of experience may be substituted in lieu of the bachelor's degree on a 1:1 basis.

All Case Managers complete training for the HCBS settings criteria via the online training platform. Case Managers also complete training on person-centered service planning, including Person-Centered Thinking; Person-Centered Assessment; requirements for identifying person-centered outcomes; and every section of the DDS person-centered service plan (the Individual Plan or the Plan) templates.

In addition, quarterly refresher trainings are provided to address any trends that arise with the person-centered service plan and/or the person-centered service plan development process.

- ☐ **Social Worker**

Specify qualifications:

- ☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ☒ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ☐ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

--

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
- ☐ An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
- ☐ Direct oversight of the process or periodic evaluation by a state agency;
- ☐ Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
- ☐ Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The Personal Support Team (Team) meets at least annually to develop the Individual Plan (Plan). The purpose of the meeting is to discuss the member's preferences, goals and desires for the next year and guide the direction and course of the Plan/plan of care. The member identifies whom he/she desires to participate in the development of the Plan. A discussion of the member's needs and options available to meet those needs is included. Options include the freedom to self direct some services. The Case Manager explains the opportunities, responsibilities, potential liabilities and risks of self direction and also explains that some services available through self direction are not available as traditional waiver services. The member and/or their representative is informed that if the Team determines a need for a particular service that is only available through the self directed option, the service will only be authorized for members who elect to self direct the service.

Using the person-centered planning approach, the Plan is developed by the Team, representation in which includes the member, his or her Case Manager and the members legal guardian and/or the member's choice of an advocate if there is one. Others may be included depending on the member's needs and preferences. The Team is composed of individuals selected by the member who know and work with the member or whose participation is necessary to achieve the outcomes desired by the member. Team meetings, including individual Plan meetings, may be conducted via HIPAA compliant teleconference or video conference. The member and his/her representative are informed of freedom of choice of provider and given assistance if needed in locating a qualified service provider. The member and their guardian participate in development of the Plan and have the option of a written or electronic signature to document and provide informed consent for services, choice of providers and implementation of the Plan. The planning process reflects the member's cultural considerations, is provided in plain language, in an accessible manner, and provides needed language services or aides. Members, their guardians, and providers responsible for service plan implementation may document their agreement to implement the plan in written or electronic form when using a HIPAA compliant phone call or video conferencing system.

An electronic signature can be a physical signature on a document that is transmitted electronically via fax or scanned or photographed then transmitted in digital form as an electronically transmitted document. An electronic signature can also be an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record that is sent or stored using electronic means. The Person-Centered Service Plan process comports with 441.301(c)(2)(ix) in that the written plan is finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

When appropriate, the Case Manager asks the waiver participant and/or others who are knowledgeable about the participant's preferences to verify that any legally responsible individual or non-legally responsible person who has decision-making authority over the selection of waiver service providers uses substituted judgement on behalf of the participant. Otherwise, the Case Manager reviews the importance of using substituted judgement on behalf of the participant with any legally responsible individual or non-legally responsible person who has decision-making authority over the selection of waiver service providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. **i. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Individual Plan (Plan) process assures that members have access to quality services and supports which foster: independence, learning, and growth; choices in everyday life; meaningful relationships with family, friends, and neighbors; presence and participation in their communities; dignity and respect; positive approaches aimed at skill enhancement; and health and safety.

DHS/DDS employs a service planning, implementation, and monitoring process that focuses on the needs, desires, and choices of the member. The Personal Support Team (Team), as described in Appendix D-1:c, is led by the DHS/DDS Case Manager and the member and/or his or her guardian, family member or advocate, develops the service plan. The Case Manager develops a plan of care consistent with the Plan.

At its core, the Team, as described in Appendix D-1:c, includes the member, his or her Case Manager, the legal guardian, and the member's advocate(s), if there is one, who may be a parent, a family member, a friend, or another who knows the member well. The member is assured the opportunity to select an individual to serve as an advocate.

Depending on the needs of the member and the issues to be addressed, the Team, as described in Appendix D-1:c, may include others. The selection of these additional Team, as described in Appendix D-1:c, members reflects the choices of the member. The Case Manager identifies service providers for selection by the member or legal guardian.

To respect the dignity and privacy of the member, the Team, as described in Appendix D-1:c, is no larger than is necessary to plan for and implement the services needed to achieve the member's desired outcomes. The Team, as described in Appendix D-1:c, is large enough to possess the expertise and capacity necessary to address the member's needs, but not so large as to intimidate the member or to stifle participation on the part of the member or his or her representatives.

Prior to the initial and each annual Team meeting, the Case Manager consults with the member and the member's advocate or legal guardian, if there is one, to review the individual situation, including the member's desired vision and progress in attaining the vision. The Case Manager also gathers information regarding services received in addition to those that may be provided by the waiver. This information is provided to the Team by the Case Manager. This information also becomes part of the Individual Plan, which is monitored by the Case Manager. At this time, the member and the member's advocate or legal guardian are informed of services available under the waiver and of other sources of services in the community and under the State Plan. Among the questions explored are whether the member is satisfied with the results of the Plan and whether outcomes need to be revised based on the progress achieved or on changing circumstances in the member's life. This review provides a clear agenda for the Team meeting and assures the member's input and participation.

The Case Manager and other Team, as described in Appendix D-1:c, members assure early intervention and prevention by the Team, as described in Appendix D-1:c, when changes occur. Events such as the loss of a loved one, change in roommates, staff, schedules, health changes, or the loss of a job prompt a re-assessment of needs, services, and supports.

An individual assessment process forms the basis for developing a Plan. Psychological, social, and functional assessments are completed prior to the development of a Plan. The social, and functional assessments are reviewed and updated at least annually. Consistent with a person-centered focus, the Case Manager assures completion of a review and update at least annually of necessary assessments to support the need for services, as well as assessment of the skills, supports, and needs of the member.

Assessments address the member's needs and choices for supports and services related to: personal relationships; home; employment, education, transportation; health and safety; leisure; social skills; and communication. The Team, as described in Appendix D-1:c, identifies potential areas in which the member's safety is at risk and develops plans to address these risks as part of the Plan.

Planning focuses on the needs and outcomes the member wishes to achieve. The Team, as described in Appendix D-1:c, considers the preferences of the member first and family, friends, and advocates secondarily.

The Plan is a written document that describes the outcomes desired by the member and prescribes the services and supports necessary to achieve those outcomes. Each Plan includes:

- (1) basic demographic information, including emergency information and health and safety concerns;
- (2) assessment information;
- (3) description of services and supports prescribed by the Team, as described in Appendix D-1:c,;
- (4) outcomes to be achieved;
- (5) action steps or methods to achieve the outcomes, including:
 - (A) the means to assess progress;
 - (B) the names of persons or the agency positions responsible for implementing each part of the Plan; and
 - (C) target dates by which each segment of the Plan is to be completed or evaluated for possible revision;
- (6) methods to address health risks and needs;
- (7) community participation strategies and activities;
- (8) identification of all needed staff training, with required time lines for completion, in accordance with OAC 340:100-3-38; and
- (9) medication support plan, as explained in OAC 340:100-5-32.

Team, as described in Appendix D-1:c, members implement responsibilities identified in the Plan or in DHS/DDS or OHCA policy. Implementation of the Plan may only be delegated to persons who are appropriately qualified and trained.

The Case Manager ensures the Team, as described in Appendix D-1:c, makes maximum use of services which are available to all citizens and assures the Team, as described in Appendix D-1:c, identifies all needed services and supports.

The Case Manager assures the services and supports developed by the Team, as described in Appendix D-1:c, support the member's own network of personal resources. The willing efforts of family members or friends to support areas of the member's life are not replaced with paid supports.

Each member served has a single, unified Plan. All services and supports, both waiver and non-waiver, are an integral part of the Plan. The DHS/DDS Case Manager is responsible for coordinating and monitoring services, both waiver and non-waiver. Health care needs are an integral part of the planning process. Programs involving professional and specialized services are jointly developed to assure integration of service outcomes. The Team, as described in Appendix D-1:c, ensures that services and supports: are integrated into the member's daily activities; take advantage of every opportunity for social inclusion; reflect positive approaches aimed at skill enhancement; and make use of the least intrusive and least restrictive options. Providers responsible for carrying out the Plan sign the Plan's signature sheet either in-person or via electronic signature.

An electronic signature can be a physical signature on a document that is transmitted electronically via fax or scanned or photographed then transmitted in digital form as an electronically transmitted document. An electronic signature can also be an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record that is sent or stored using electronic means. The Person-Centered Service Plan process comports with 441.301(c)(2)(ix) in that the written plan is finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

Each Team, as described in Appendix D-1:c, member responsible for services identified in the Plan sends a quarterly summary of progress on assigned outcomes to the member's Case Manager. At the request of the member, or the legal guardian, or if the performance of a Team, as described in Appendix D-1:c, member reveals a course of action which is not in the best interest of the member, which is destructive towards the collaborative process of the Team, as described in Appendix D-1:c, or which violates OKDHS policy or accepted standards of professional practice, the Case Manager notifies that Team, as described in Appendix D-1:c, member by letter that his or her services on the Team, as described in Appendix D-1:c, are no longer required.

The DHS/DDS Case Manager monitors all aspects of the Plan's implementation. DHS/DDS case management may conduct required monitoring using Health Insurance Portability and Accountability Act (HIPAA) compliant phone and/or video conferencing. The DHS/DDS case management electronic database, Client Contact Manager (CCM), reflects the Case Manager's review of the progress.

The Case Manager routinely asks the member and his or her family, guardian, or advocate about their satisfaction

with services and supports, and initiates appropriate action to identify and resolve barriers to consumer satisfaction. The Plan is updated as required by ongoing assessment of progress and needs. It is also updated in anticipation of foreseeable life events.

The DDS Intake Case Manager submits the temporary interim service plan to OHCA to determine waiver eligibility. The DDS Case Manager holds a meeting within 30 days of the initial plan of care start date to gather additional information to finalize the full-service plan. The full-service plan is completed no later than 60 days after the initial plan of care start date.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

- ☒ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**
- ☐ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**
 - ☐ **A specific and individualized assessed need for the modification.**
 - ☐ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
 - ☐ **Less intrusive methods of meeting the need that have been tried but did not work.**
 - ☐ **A clear description of the condition that is directly proportionate to the specific assessed need.**
 - ☐ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
 - ☐ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
 - ☐ **Informed consent of the individual.**
 - ☐ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The Personal Support Team (Team) identifies potential areas in which the member's safety is at risk including physical, emotional, medical, financial, or legal risks, or risk to community participation; how often, when and where the risk to safety may occur. The Plan also describes the positive approaches, supports services and actions needed or being used to reduce or eliminate the risk. Back-up plans are developed on an individual basis. The back-up plan identifies who is responsible for ensuring back-up services are available and who is responsible for responding to emergencies. The back-up plan must be reviewed and updated as changes occur or as needed. The back-up plan addresses services and supports needed to prevent or reduce risk. Case Managers are responsible for ongoing monitoring and oversight of the member's Individual Plan including back-up plans. Case Managers are required to make revisions and modifications, as appropriate, to the member's Individual Plan to ensure the health and safety of the member.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

At least annually, members are informed of and acknowledge their right to freedom of choice in providers. DHS/DDS Case Managers ensure members have information about qualified waiver providers. The Case Manager identifies available providers and provides available information regarding the providers performance. They may assist the member in contacting and interviewing potential providers. They also assist members when they wish to change providers. The assistance provided is based on the needs and choices of the member.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

For individuals determined eligible for the waiver, a plan of care is developed, directed by the member/family/guardian and assisted by the DHS/DDS Case Manager. All initial plans of care are submitted to the OHCA Level of Care Evaluation Unit for review and confirmation of a diagnosis of Global Developmental Delay or Intellectual Disability (ID), that the ID diagnosis was made before the member's 18th birthday and that the proposed delivery of services is consistent with the member's level of care need. Once this process has been completed the initial eligibility determination is approved by OHCA. A diagnosis of borderline intellectual functioning would constitute a denial by OHCA. Any errors or service discrepancies are directed to the Case Manager for correction. All waiver plans of care are subject to review and approval by both DHS/DDS (the operating agency) and the LTSS of the OHCA (the Medicaid agency). OHCA does not review and approve all plans of care prior to implementation; however, all are subject to the Medicaid Agency's approval. DHS/DDS does review a sampling of member charts which includes the plan of care. Reviewed plans of care are compared to policy guidelines, the functional assessment, and the narrative written detailing the member's living environment, physical and mental limitations and overall needs. All plans of care are subject to the approval of the Medicaid Agency and are made available by the operating agency upon request. OHCA randomly reviews plans of care through several authorities within the Medicaid Agency, such as Program Integrity and Accountability, Quality Assurance/Improvement and Claims/Coding and Integrity Units. In the event provider billing practices are suspect, all pertinent information is forwarded to the OHCA Program Integrity and Accountability department.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ☐ Every three months or more frequently when necessary
- ☐ Every six months or more frequently when necessary
- ☒ Every twelve months or more frequently when necessary
- ☐ Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following (*check each that applies*):

- ☐ Medicaid agency
- ☒ Operating agency
- ☒ Case manager

☐**Other***Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The DHS/DDS Case Manager, who is an employee of the State, monitors implementation of the member's service plan to determine the plan's effectiveness in meeting the needs of the member, to ensure the member's free choice of providers and to ensure the health and welfare of the member is protected. Case Managers assess services rendered to each member at least quarterly. A face-to-face contact occurs at least twice annually. Monitoring may also be conducted by DHS/DDS case management and Quality Assurance staff, utilizing HIPAA compliant phone calls or video conferencing. The annual review process includes a discussion of the needs of the member and confirmation that all identified needs are addressed by waiver, non-waiver, or natural supports. The annual review process includes a discussion of the member's back-up plan, whether it was necessary to implement the back-up plan and if so whether the back-up plan was effective; any necessary changes are made to the back-up plan and included in the member's Individual Plan. Back-up plans address back-up housing plans and back-up staffing arrangements.

The operating agency performance monitoring process is a record review of the DHS/DDS Case Manager record, based on a statistically significant random sample of members receiving supports through the waiver. One quarter of the representative sample is monitored each quarter. This results in a complete representative sample being reviewed each year. The record reviews include a review of service plans to assure: all member needs are addressed and preferences considered, by waiver, non-waiver, or natural supports; they are developed according to policy and updated/revised as needed ensuring an interim meeting was held within 30 days of identification or notification of the need for change in authorization of waiver services; services are delivered in accordance with the service plan including the type, scope, amount and frequency specified in the service plan; and that members are afforded choice between waiver services and institutional care and between/among waiver services and providers. The record review process includes a discussion of the member's back-up plan, whether it was necessary to implement the back-up plan and if so whether the back-up plan was effective; any necessary changes are made to the back-up plan and included in the member's individual plan. Deficiencies are recorded and reported to DHS/DDS Community Services Unit for correction.

The operating agency performance monitoring process is conducted by the DHS/DDS Quality Assurance Unit. CMS waiver assurances have been identified for monitoring and the record review process provides the evidence of compliance. DHS/DDS Quality Assurance staff reviews are based on CMS waiver assurances. The results of these reviews are recorded on monitoring reports, resulting in the creation of data. Review results are entered into a data base and reported to the respective DHS/DDS Area office for remediation. An annual report and other reports as needed are generated for the Quality Management Committee, of which OHCA is a member. OHCA also has access to all performance monitoring activities via a web based system.

If at any time the Case Manager believes that the member is at risk of harm, the Case Manager takes immediate steps necessary to protect the member. Case Managers also receive periodic progress reports from persons who are designated responsible to implement the member's service plan. If the Case Manager determines that services are not effectively addressing the needs or preferences of the member, the Case Manager reconvenes the member's Personal Support Team (Team) to make necessary changes. If it is determined the provider is not implementing the Plan as required or the provider does not meet contractual responsibilities or policies, the Case Manager consults with the relevant provider to secure a commitment for necessary service changes within an agreed upon timeframe. If necessary changes are not accomplished within the specified time frame, the DHS/DDS Case Management Supervisor intervenes to secure commitments from the provider for necessary change. If the service deficiency is still not resolved as a result of the intervention, a referral for an Administrative Inquiry by the DHS/DDS Quality Assurance Unit is initiated, which may result in provider sanction.

Each Individual Plan includes a back-up plan. The back-up plan identifies who will provide necessary supports if the provider does not as well as housing alternatives should a member's home be unavailable for some reason.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can**

monitor service plan implementation. (Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. By checking each box, the state attests to having a process in place to ensure:

- ☐ Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
- ☐ An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
- ☐ Direct oversight of the process or periodic evaluation by a state agency;
- ☐ Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
- ☐ Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. **Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

and percent of member's records reviewed who had Individual Plans that were adequate and appropriate to their needs and personal goals as indicated in the assessments. N: # of member's records reviewed who had Individual Plans that were adequate and appropriate to their needs and personal goals as indicated in the

assessments. Denominator: Total number of member's records reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of member records reviewed who had Individual Plans that contain methods to address safety and health risks and assessed needs. Numerator: Number of member records reviewed who had Individual Plans that contain methods to address safety and health and assessed needs. **Denominator:** Total number of member records reviewed.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval =

		95% confidence level and +/- 5% margin of error
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of member's records reviewed who had Individual Plans that included a back-up plan. Numerator: Number of member's records reviewed who had Individual Plans that included a back-up plan. Denominator: Total number of member's records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

- b. Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.**

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.**

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of member's records reviewed who had service plans

updated/reviewed within 40 days of the notification of the change in the waiver member's needs. Numerator: Number of member's records reviewed who service plans updated/reviewed within 40 days of the notification of the change in the member's needs. Denominator: Total number of member's records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of member's records reviewed who had a quarterly summary of progress on assigned outcomes submitted by the provider agency as specified by policy. Numerator: Number of member's record reviewed who had a quarterly summary of progress on assigned outcomes submitted by the provider agency as specified by policy. Denominator: Total number of member's records reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval =

		95% level of confidence and +/- 5% margin of error
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

Performance Measure:

Number and percent of member's records reviewed whose Individual Plan meeting was held on or before the date of the plan of care expiration. Numerator: Number of member's records reviewed whose Individual Plan meeting was held on or before the date of the plan of care expiration. Denominator: Total number of member's records reviewed.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other	

	Specify: 	
--	-------------------------	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

and percent of member's records reviewed, with a situation identified in which a Team meeting was held within 30 days of the identification/notification of the need for a change. N: Number of member's records reviewed with a situation identified in which a Team meeting was held within 30 days of the identification/notification of the need for a change. Continued in Main B Optional

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review

☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify:

Performance Measure:

Number and percent of member's records reviewed who had service plans updated/reviewed at least annually. Numerator: Number of member's records reviewed who had service plans updated/reviewed at least annually. **Denominator:** Total number of member's records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

	☐ Other Specify: 	
--	---	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

d. Sub-assurance: Participants are afforded choice between/among waiver services and providers.**Performance Measures**

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of member's records reviewed who received the type, amount, duration, scope and frequency of the services identified in the Individual Plan.

Numerator: Number of member's records reviewed who received the type, amount, duration, scope and frequency of the services identified in the Individual Plan.

Denominator: Total number of member's records reviewed.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% level of confidence and +/- 5% margin of error
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of member's records reviewed who received from the provider agency the type, amount, duration, scope and frequency of services in the Individual Plan. Numerator: Number of member's records reviewed who received from the provider agency the type, amount, duration, scope and frequency of services in the Individual Plan. Denominator: Total number of member's records reviewed.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error

☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

e. *Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of member records reviewed with a completed and signed freedom of choice form that specified choice was offered between/among services and providers. Numerator: Number of member records reviewed with a completed and signed freedom of choice form that specified choice was offered between/among services and providers. Denominator: Total number of waiver member records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

	☐ Other Specify: 	
--	---	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The "Operating Agency Performance Monitoring" Data Source is based on a proportionate representative sample. The data source for the proportionate representative sample is the Client Contact Manager, the system used to enter and maintain records on each active waiver participant. The sampling approach is less than 100% with a 95% confidence level and a 5% margin of error.

A representative sample will be generated at the beginning of the waiver year. The sample will be divided as evenly as possible over the following four quarters. For each waiver participant included in the sample, record reviews will be conducted by DDS Quality Assurance survey staff for each survey question (performance measure) applicable to the individual.

Quality Assurance survey staff review the complete records of each individual in the sample to obtain the information needed to determine compliance with the thirteen performance measures in Appendix D. All of these performance measures use a sampling approach less than 100%. PMs a.i.c.3 and a.i.d.2 are collected for the Quality Assurance Provider Performance Monitoring Tool. The remainder of the Performance Measures are collected from the Operating Agency Performance Monitoring survey tool.

Reference to "Q" numbers or numbers 1000-6000 in the Data Source field represent the OKDHS/DDSD performance tool identifier.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Individual problems are identified by area surveys or provider performance monitoring. State Office staff monitor each individual citation to ensure corrections have been completed. Any survey questions that do not meet the 86% threshold established by CMS are considered to indicate the need for development of further training review processes. State Office staff meet with providers to remediate individual issues/citations. State Office staff meet with field staff to discuss the development of new methodologies to enhance accurate and timely performance. Follow-up on operating agency performance monitoring is completed by DHS/DDS program staff quarterly to ensure 100% correction of identified problems. Program staff maintain documents to verify correction.

Follow-up on provider performance monitoring is completed by DHS/DDS Quality Assurance Unit staff to ensure 100% correction. Follow-up survey documents are completed to verify correction. Provider agencies are required to correct deficiencies within 60 days. Failure to do so results in review by the DHS/DDS Performance Review Committee which may impose additional sanctions such as vendor hold. If, after sanctions and follow-up, a provider remains non-compliant, DHS/DDS recommends Agreement termination action to OHCA.

ii. Remediation Data Aggregation**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Applicability (from Application Section 3, Components of the Waiver Request):

- **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Once a plan of care is developed for a member, a DHS/DDS Case Manager will offer the choice of either the participant directed or provider managed service delivery method, for services approved for participant direction. In addition, the DHS/DDS Case Manager explains that services may be provided through a combination of community resources, SoonerCare services such as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, as well as waiver services. DHS/DDS Case Managers help identify concerns and coordinate, locate and secure needed services. DHS/DDS Case Managers also help families recognize natural supports that may already be available. A member may have all self-directed services (SDS), all provider-managed services or a combination of self-directed and provider managed services. The opportunity to choose self-direction is offered during each annual Team, as described in Appendix D-1:c, meeting. The DHS/DDS Case Manager will provide information regarding options and the member's responsibilities and potential liabilities. Training related to SDS is conducted by DHS/DDS, to include a component related to potential liabilities. In addition, the member receives a manual describing SDS services, responsibilities as well as potential liabilities.

Members who opt for SDS will develop an individualized budget for services which they will self direct. DHS/DDS Case Managers will assist the member to explore options and develop a self directed budget. The individual cost limit of this waiver is used to establish a budget for participant directed services included in the member's plan of care. Each member (or their personal representative) will have both the employment and budget authority over the self directed services.

DHS/DDS will serve as the Financial Management Service (FMS) in a Government Fiscal Employer Agent (FEA) model. DHS/DDS will also operate as an Organized Health Care Delivery System (OHCD) and use a subagent in accordance with Section 3504 of the IRS code and Revenue Procedure 80-4 and Notice 2003-70. Based on the member's Plan and budget, the subagent sets up an individual account, makes payments that follow the authorized budget, handles all payroll functions on behalf of the member who hires service providers and other support personnel, provides the member with a monthly report of expenditures and budget status, answers inquiries, solves related problems, and provides DHS/DDS Case Managers with documentation of expenditures. DHS/DDS has an Interagency Agreement with the State's Medicaid agency.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. Select one:

- **Participant: Employer Authority.** As specified in **Appendix E-2, Item a**, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for

participants who exercise this authority.

- **Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- **Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

- **Waiver is designed to support only individuals who want to direct their services.**
- **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Once a plan of care is developed for a member, a DHS/DDS Case Manager will offer the choice of either the participant directed or provider managed service delivery method, for services approved for participant direction. The DHS/DDS Case Manager will provide information regarding options and the member's responsibilities and potential liabilities. In addition, the DHS/DDS Case Manager explains that services may be provided through a combination of community resources, SoonerCare services such as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, as well as waiver services. DHS/DDS Case Managers help identify concerns and coordinate, locate and secure needed services. DHS/DDS Case Managers also help families recognize natural supports that may already be available.

Once a member elects to self direct his/her services and supports, the member or their representative must enroll and complete a 4-6 hour course in self-direction prior to implementation of self directed services. This training addresses:

- staff recruitment;
- hire staff common law employer;
- orient and instruct staff in duties consistent with approved service specifications;
- supervise staff including scheduling of staff and services;
- evaluate staff performance;
- discharge staff (common law employer);
- philosophy and history of self direction;
- OHCA policy governing self direction in Oklahoma;
- individual budgeting including determining staff wages and benefits subject to State limits and the amount paid for services within State limits;
- developing a self directed support plan;
- cultural diversity; and
- rights, risks and responsibilities.

Training also includes an overview of the roles and responsibilities of the DHS/DDS Case Manager, FMS subagent and the member.

The FMS subagent will provide a packet of information and instructions on forms, timesheets, timeframes for completion of forms, payment calculation sheets for the SD-HTS, vendor payment forms, worker compensation information, reporting individual account information, budgeting tips to self-direction participants as well as instruction and training on use of EVV system. In the event the EVV system is not available, the Employer of Record may enter the employee's hours electronically through a separate time entry system. The employee may document their time on a timesheet for manual entry if the EVV system is unavailable.

Members may contact the DHS/DDS Case Manager or FMS subagent at any time for problem resolution, technical assistance or guidance.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

- ☐ **The state does not provide for the direction of waiver services by a representative.**
- ☒ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: (*check each that applies*):

- ☒ **Waiver services may be directed by a legal representative of the participant.**
- ☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

An employer of record is a legal representative or non-legal representative of the member who may direct self-directed waiver services, but cannot be paid to provide SD services. Members may appoint a family member, another relative or a friend to direct waiver services as an employer of record on their behalf. If a member is married, his/her spouse may direct the spouse's services or be a self-directed services provider for the adult member, but not be both. The proposed provider is the choice of the member or employer of record, which is supported by the team.

An appointed representative must:

- be 18 years of age or older;
- be approved by the member or legal guardian to act in the capacity of a representative;
- demonstrate knowledge and understanding of the member's needs and preferences;
- comply with self-directed services responsibilities and policy;
- sign the Self Directed Services Agreement with the FMS subagent and member in which the appointed representative agrees to assist the member in participating in the program. The agreement includes conditions related to assistance with fiscal management, training requirements, critical incident reporting, etc.; and
- complete the required SDS training.

Safeguards:

- The member or the member's employer of record, DHS/DDS Case Manager and FMS subagent will monitor use of allotted budget to assure only approved services are provided and compensated.
- The FMS subagent will require receipts for all prior authorized purchases in which the members or their representative submit a vendor request form for reimbursement.
- Members choosing to self-direct are included in the random sample for monitoring conducted by DHS/DDS Quality Assurance Unit. Additionally, case management monitoring, including progress report reviews, serve to ensure the best interest of the member.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Habilitation Training Specialist Services	☒	☒
Self Directed Goods and Services (SD-GS)	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- **Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

☒ **Governmental entities**

☐ **Private entities**

- **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- ☐ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

- ☒ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

DHS/DDS serves as a Financial Management Service (FMS) in a Government Fiscal Employer Agent (FEA) model and also operates as an Organized Health Care Delivery System (OHCDS) using a subagent. A Request For Proposal (RFP) was initiated by the State for a subagent in order to procure an entity in compliance with general Oklahoma Department of Central Services contracting and purchasing rules and State purchasing law including but not limited to 74 O.S. 85 et. seq. and 74 O.S. 4243. The entity was required to have a minimum of five years experience working with self directed service budgets and payroll. The entity has entered into an Agreement with DHS/DDS to serve as a subagent and has also signed an Agreement with the State's Medicaid agency, Oklahoma Health Care Authority (OHCA), to perform billing transactions on behalf of DHS/DDS. DHS/DDS has an Interagency Agreement with OHCA.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Payment was established during the contracting process. The subagent will receive an administrative fee. Services are paid as a flat monthly charge per member.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
☒ **Collect and process timesheets of support workers**
☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
☒ **Other**

Specify:

Obtains criminal background check and completes required registry checks.

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
☒ **Track and report participant funds, disbursements and the balance of participant funds**
☒ **Process and pay invoices for goods and services approved in the service plan**
☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☐ Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- ☒ Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- ☒ Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget
- ☒ Other

Specify:

Executes and holds OHCDS provider agreements as authorized.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

DHS/DDS reviews reports, invoices or other valid indications of performance to assure all contract terms and conditions of contract with the subagent are met. The subagent is required to be bonded and/or have sufficient liability insurance to protect members and the State against loss of funds, fraud or mismanagement. The subagent is required to provide an annual audit as well as monthly reports. (b) DHS/DDS, Oklahoma Department of Central Services and OHCA. OHCA randomly reviews plans of care through several authorities within the Medicaid Agency, such as Program Integrity and Accountability, Quality Assurance/Improvement and Claims/Coding and Integrity Units. The DDS Program Manager for self directed services is responsible for actual monitoring of all programmatic aspects of the contract including Consumer Satisfaction Surveys. (c) Monthly and more frequently upon request.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- ☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The Case Manager provides the following information and assistance to the member in support of self direction:

- develop the plan of care with the member;
- ensures that services are initiated within required time frames;
- facilitate the development of and review the status of the member's self directed services budget;
- conduct ongoing monitoring of the implementation of the plan of care and member health and welfare;
- arrange alternative emergency back-up services as necessary in the event that the emergency back-up plan provided for in the plan of care cannot be employed;
- specify additional staff qualifications in the Individual Plan (IP) based on member needs and preferences so long as such qualifications are consistent with approved qualifications;
- specify additional service provider qualifications consistent with approved qualifications;
- in the IP, specifies how services are provided, consistent with approved service specifications; and
- refers providers to the Financial Management Service (FMS) subagent for enrollment.

The Case Manager also may assist in locating and securing services and other community resources that promote community integration, community membership and independence, as provided in the member's plan. The Case Manager will be provided training regarding self direction including their roles and responsibilities in facilitating the development and review of the self directed budget, arranging back-up services and the roles and activities related to self direction.

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Habilitation Training Specialist Services	☐
Specialized Medical Supplies and Assistive Technology	☐
Self Directed Goods and Services (SD-GS)	☐
Supported Employment	☐
Environmental Accessibility Adaptations and Architectural Modification	☐
Occupational and Physical Therapy	☐
Prevocational Services	☐
Respite	☐
Family Training	☐
Respite Daily	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (*select one*).

- ☒ **No. Arrangements have not been made for independent advocacy.**
- ☐ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

- l. Voluntary Termination of Participant Direction.** Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Members who decide to discontinue self directing their services may return to traditional waiver services. Their DHS/DDS Case Manager assists them in returning to traditional waiver services including assistance with free choice of any willing and qualified provider. The DHS/DDS Case Manager assists in developing a revised plan for traditional waiver services and the funding will follow them back to traditional waiver services. Since the option to self direct is covered under the same waiver, there is no disruption of services. Members continue to self direct until traditional waiver services are in place.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Members may be terminated involuntarily from self direction and offered traditional waiver services under the following circumstances:

- immediate health and safety risks associated with self-direction;
- intentional misuse of funds following technical assistance and support from the DHS/DDS Case Manager, FMS and its subagent;
- fraud; and
- when a member or their representative continues to violate SDS waiver policies and procedures even after training and technical assistance by DHS/DDS. Some examples would be: not providing receipts with vendor request forms to the FMS subagent, failure to submit timesheets to the FMS subagent in a timely manner, failure to provide reports to the DHS/DDS Case Manager, failure to report critical incidents or refusal to follow outcome related activities.

When action is taken to terminate the member from self directed services involuntarily, the DHS/DDS Case Manager assists the member in accessing needed and appropriate services through traditional waiver services, ensuring that no lapse in necessary services occurs for which the member is eligible. The Fair Hearing process and notice apply when any action is taken to involuntarily terminate self directed services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		72
Year 2		80
Year 3		88
Year 4		96
Year 5		104

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

- ☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- ☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- ☒ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☒ **Hire staff common law employer**
☒ **Verify staff qualifications**
☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The cost is paid by the member out of the IHSW-C self directed budget.

- ☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

The State's method to conduct background checks is the same method described in Appendix C-2-a.

- ☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☒ **Determine staff wages and benefits subject to state limits**
☒ **Schedule staff**
☒ **Orient and instruct staff in duties**
☒ **Supervise staff**
☒ **Evaluate staff performance**
☒ **Verify time worked by staff and approve time sheets**
☒ **Discharge staff (common law employer)**
☐ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-

1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- ☐ Reallocate funds among services included in the budget
- ☒ Determine the amount paid for services within the state's established limits
- ☒ Substitute service providers
- ☒ Schedule the provision of services
- ☒ Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- ☒ Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- ☒ Identify service providers and refer for provider enrollment
- ☐ Authorize payment for waiver goods and services
- ☒ Review and approve provider invoices for services rendered
- ☐ Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The amount of the individual budget is based on the amount authorized in the plan of care for the services the member has elected to direct and cannot exceed the cost limit described in section B-2:a of this application. Each member has a unique individual budget based on the needs of the member as determined by the member and Personal Support Team, as described in Appendix D-1:c. Policy related to self-directed services, to include budget methodology, can be found on the DHS/DDS website. The web site address is listed in the Helpful Web Sites section of the self-directed services manual provided to members. The DHS/DDS Case Manager assists the member in updating the budget during the plan of care year as necessary. The member's individualized budget accounts for the actual cost of administrative activities performed by the FMS subagent such as obtaining criminal history and/or background investigations of staff, completion of required registry checks, processing payroll, etc. Individualized budget methodology is described in OHCA policy and available for public viewing via the web at any time.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the

participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The DHS/DDS Case Manager informs the member of the budget amount, in accordance with approved rules, during the annual plan of care meeting. Members are advised by the DHS/DDS Case Manager of their right to request a Fair Hearing and informed of the procedure for doing so during the planning process.

During Personal Support Team (Team) meetings, as described in Appendix D-1:c, DHS/DDS Case Managers inform members and member representatives of their right to request a Team, as described in Appendix D-1:c, meeting, which may include a request for an adjustment to the budget/service plan, at any time.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one:*

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FMS subagent and DHS/DDS Case Manager work with the member to ensure the budget is utilized according to the authorized budget and SDS Support Plan. When problems are identified, the FMS subagent and DHS/DDS Case Manager work together with the member to find solutions and make changes as needed. The FMS subagent sets up an individual account, based on the member's approved budget, makes expenditures that follow the authorized budget, provides the member with a monthly report of expenditures and budget status, and provides the DHS/DDS Case Manager with access to the member's individual account information. The DHS/DDS Case Manager utilizes the information provided to monitor expenditures. The FMS subagent also provides DDS State Office staff with a monthly report of expenditures. In addition, members are issued a login identification number and password which may be used to view account information via the FMS subagent web site. These methods are used to prevent premature depletion of the individual budget as well as budget underutilization.

Appendix F: Participant Rights

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The "Documentation of Consumer Choice" form explains the right to a Fair Hearing and provides information regarding the process for requesting a Fair Hearing. The form also includes a section requiring the choice between Home and Community-Based Services (HCBS) under the Waiver and institutional care and acknowledges the freedom of choice of providers. This form is reviewed annually and a copy is maintained electronically in the case management information system. The member and/or his/her representative are informed of all changes in service provision (denial, reduction, suspension or termination of services) through a written notice. These notices are generated automatically by the authorization system or, in the case of denial or termination, by the DHS. This notice includes the information regarding the method of requesting a Fair Hearing. In addition, any adverse action relating to SoonerCare eligibility generates a notice from the Information Management System (IMS) which includes information relating to requesting a Fair Hearing. The DHS/DDS Case Manager assists the member or their representative in requesting and preparing for a Fair Hearing. The notice specifies that services may continue pending the outcome of the appeal, if requested. The Hearing process and other information regarding this process is explained in OAC 340:2-5 and based on Section 168 of Title 56 of the Oklahoma Statutes and applicable Federal regulations.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ☒ **No. This Appendix does not apply**
- ☐ **Yes. The state operates an additional dispute resolution process**
 - **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Do not complete this item.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ☐ **No. This Appendix does not apply**
- ☒ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register**

grievances or complaints concerning the provision of services under this waiver

- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The Oklahoma State Department of Health (OSDH) Office of Client Advocacy (OCA) is responsible for the operation of the grievance system.

- **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The OSDH grievance system is a multi-tiered system that affords members the opportunity to have their concerns heard and addressed beginning at the local level and continuing, through an appeals process, to the Director of the DHS.

The OSDH Office of Client Advocacy's (OCA) administrative rules set forth the procedures to be followed as well as the timelines for each stage of the process (OAC 340:2-3-45). Notice of the member's right to file a grievance is provided upon initiation of services and annually thereafter. Timelines for response range from five working days for first level resolution to 15 days for the DHS Director's review of an appealed grievance. DDS designates a staff person to serve as the Local Grievance Coordinator (LGC). The LGC assists members at every stage of the process and monitors each grievance filed to ensure timely and adequate response.

Grievances may be filed by any person receiving services from DHS/DDS or by anyone interested in the welfare of a member. The subject matter of the grievance may be about any policy, rule, decision, behavior, action or condition made or permitted by the DHS, its employees or other persons authorized to provide care including contract provider agencies and their employees.

DHS/DDS contract provider agencies are required by policy to establish a grievance process that must be approved by OCA. The process must include, at a minimum, notice of the member's right to file a grievance and to a reasonable response, timelines for response, right to appeal and the designation of an LGC who is responsible for implementation of the agency's grievance process. Timelines for response to grievances range from five working days for first level resolution to ten working days for the agency's Board of Directors (or appeals committee designated by the Board).

The OCA ensures the quality of grievance systems by establishing minimum standards and through an ongoing monitoring program. The Advocate General and OCA staff have immediate and unlimited access to members, staff and provider agency files, records and documents relating to grievance procedures and practices.

The OCA grievance system in no way undermines the member's right to request a Fair Hearing. DHS policy provides that DHS/DDS waiver members are granted Hearings if the application for services is denied; when resources are sufficient for initiation of Home and Community-Based Waiver services (HCBS) and action is not taken within 45 days; or the client, family, or guardian is aggrieved because of DHS actions to suspend, terminate or reduce services. All other complaints or grievances are made to OCA and are addressed in accordance with OCA policies and procedures (OAC 340:2-5-61). Case Managers assure that members understand that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing. Case Managers provide the information annually to the members, their advocates and guardians regarding both processes. They are also available to assist in requesting a Fair Hearing or filing a grievance.

DHS/DDS Quality Assurance staff evaluate all service-related complaints received. The type of complaint is not limited. The QA staff establishes a reasonable timeframe, not to exceed 60 days for correction, and informs individuals responsible for making or overseeing the necessary corrections of actions needed to facilitate change or correction. These may include problem solving or other more extensive oversight or change. The DHS/DDS QA Administrator may authorize an Administrative Inquiry (AI) in response to a complaint regarding support services made by members or any interested person (OAC 340-100-3-27.1). An Administrative Inquiry does not affect a members right to a Fair Hearing, rather, it provides an opportunity to determine if the member's rights are being protected.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

☒ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

☐ **No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

CRITICAL INCIDENT REPORTING REQUIREMENTS: DHS policy directs providers who have entered into Agreements with OHCA to provide waiver services to report critical and non-critical incidents involving the health and welfare of any person receiving DHS/DDS waiver services. The contract provider ensures reporting of critical and non-critical incidents electronically via the DHS/DDS Provider Reporting System. The DHS/DDS Case Manager is notified immediately when there is a Tier 1 critical incident. If the incident occurs outside regular working hours, the DHS/DDS Case Manager is notified within one business day of observing or discovering the incident. Critical incidents are required under the following circumstances: 1) Unexplained or unanticipated death, including but not limited to death caused by abuse or neglect; 2) suspected abuse, including verbal, physical, sexual, psychological, or emotional abuse; 3) suspected neglect; 4) suspected exploitation, including financial; 5) misuse or unauthorized use of restrictive interventions or seclusion; and 6) a medication error resulting in a telephone call, visit, treatment, or consultation with a poison control center, an emergency room, an urgent care, hospitalization, or death. The service provider ensures the incident report is submitted electronically to DDS.

NON-CRITICAL INCIDENT REPORTING REQUIREMENTS: The procedures for reporting incidents considered non-critical are identical to those described for critical incidents except that immediate notification is not required. Non-critical Tier 2 Incident Reports must be provided to DHS/DDS Case Management within two business days of observing or discovering the incident. Tier 2 non-critical incidents are required under the following circumstances: 1) suicide attempt; 2) suicide threat; 3) hospital admission not due to a medication error; 4) psychiatric admission to a hospital, free-standing facility, or behavioral unit; 5) missing person; 6) alleged criminal conduct by individual receiving DDS services; and 7) law enforcement involvement due to behavioral or criminal actions of an individual receiving services. Non-critical Tier 3 Incident Reports must be provided to DHS/DDS case management within three business days of observing or discovering the incident. Tier 3 non-critical incidents are required under the following circumstances: 1) expected death due to a previously known terminal illness; 2) treatment or consultation in an emergency room or urgent care due to an unplanned illness or event; 3) serious health-related event; 4) motor vehicle accident; and 5) suspension or termination of a day program, including employment, adult day, educational, or meaningful day activities. Non-critical Tier 4 Incident Reports must be provided to DHS/DDS case management within four business days of observing or discovering the incident. Tier 4 non-critical incidents are required under the following circumstances: 1) medication error not resulting in a telephone call, visit, treatment, or consultation with a poison control center, an emergency room, an urgent care, or hospitalization or death; 2) injury requiring basic first aid; 3) physical aggression by individual receiving DDS services; 4) loss of property of individual receiving DDS services due to theft valued at \$25 or more; and 5) loss of property of individual receiving DDS services due to damage valued at \$150 or more. DHS/DDS Case Management staff are responsible for reviewing each Incident Report and taking further action when necessary. With respect to medication events, the DHS/DDS Case Manager may notify the DHS/DDS Registered Nurse if the Case Manager believes the medication error caused harm or if the Case Manager needs technical assistance on appropriate follow-up activities.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The DHS/DDS Case Manager provides information and education along with written materials to the member and his/her legal guardian or advocate regarding member rights, responsibilities, the grievance process and procedures, pertinent phone number(s) and how to report maltreatment during the meeting to develop the Individual Plan. Thereafter, information and materials are available upon request by the member, family and/or legal guardian and routinely provided during annual reevaluation. Case Managers are responsible for ongoing monitoring of the health and welfare of members and providing necessary education and intervention related to the reporting of maltreatment of members. In the event of a change in Case Manager or Case Management Supervisor, new names and phone numbers are provided.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Reports are submitted to DHS and OCA. Within DHS, two divisions are responsible for receipt, evaluation and response to critical incidents. The divisions responsible are Child Protective Services (CPS)(maltreatment of children) and Developmental Disabilities Services (DDS)(incidents identified in Appendix G-1-a that do not constitute maltreatment). OCA is responsible for investigating maltreatment of children in out of home living arrangements other than foster care as well as maltreatment of vulnerable adults by caregivers who have entered into Agreements with DHS.

DHS maintains a statewide toll free hotline for receipt of reports of maltreatment of children and adults. The hotline operates 24 hours a day, seven days a week and is staffed by Children and Family Services (CFS) personnel who are trained in APS and OCA procedures.

Within the OSDH, OCA is responsible for evaluating and investigating allegations of maltreatment of a member by a community service worker. OCA Intake determines, from available information, whether the situation presents a serious risk that requires immediate action. If an emergency response appears indicated, OCA arranges for an investigator, a law enforcement officer or an OCA advocate to personally visit with the alleged victim immediately and no later than within 24 hours.

OCA administrative rules specify extensive procedures for the conduct of investigations. The OCA investigator conducts an interview with the alleged victim within 5 working days of assignment. A separate, private interview is conducted with each alleged victim, witnesses to the alleged maltreatment, persons allegedly directly or indirectly involved in the allegation, persons with knowledge of relevant information, and each caretaker accused of the maltreatment. All interviews are tape-recorded and interpreter services are provided for persons with hearing impairments.

If the investigator becomes aware of a significant health or safety concern requiring immediate attention, he/she promptly informs appropriate DHS/DDS or Child Protective Services staff. Other persons or entities are notified as warranted. The investigator remains with the member until safety can be assured.

All cases are assigned within one working day of receipt of a referral. Investigation is commenced immediately upon receipt of a referral deemed urgent. Within 30 calendar days of disposition, the investigative process is completed and appropriate administrators notified. Within 60 calendar days from the assignment of an investigation, the OCA written investigative report is completed. OCA supervisors monitor timely completion of investigation reports and oversee completion of reports that are pending over 30 days.

When the finding does not confirm an allegation or the finding is confirmed but the accused caretaker is not a community services worker, OCA sends a copy of the report to the provider agency administrator, the DHS/DDS Director, and the applicable district attorney. When the finding confirms an allegation against a caretaker who is a community services worker, OCA submits a copy of the report to the applicable District Attorney and processes the report per the due process requirements for inclusion of the caretaker's name on the Community Services Worker Registry. When due process procedures relating to the registry have been completed, OCA sends a copy of the report to the provider agency administrator and the DHS/DDS Director. The provider agency administrator is responsible for notifying the participant or the participant's legal representative of the OCA finding. The investigative findings are approved within 30 to 60 calendar days of disposition of a referral to be investigated. Investigations resulting in confirmation against a caretaker who is a Community Services Worker are not considered final until the due process procedures relating to the Community Services Worker Registry have been completed. The timeframes for notification of the member or member's legal representative in these cases vary.

Critical incidents that do not constitute maltreatment are reviewed and evaluated by DHS/DDS. All deaths, regardless of circumstance, are reported immediately to the DHS/DDS Director or designee. The member's family member(s) or legal guardian is notified by DHS/DDS case management staff or by the respective provider agency. The member's Team, as described in Appendix D-1:c, reviews all critical incidents involving the use of an intrusive procedure or emergency intervention to ensure the use was reasonable, necessary, and consistent with the PIP or an emergency intervention, as defined in OAC 340:100-5-57(f). Critical incidents involving the use of highly restrictive procedures are reported electronically to DHS/DDS case management and DHS/DDS Positive Field Support staff within 1 business day of observing or discovering the incident. The member's Team, as described in Appendix D-1:c, meets within 5 business days of the case managers review of the incident.

All other critical incidents are reported immediately to DHS/DDS case management. If the incident occurs outside regular working hours, DHS/DDS on-call staff are notified immediately. Providers who have entered into Agreements

with OHCA to provide waiver services submit an electronic report of all critical incidents to the DHS/DDS Case Manager and DHS/DDS State Office staff within one business day of observing or discovering the incident.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Oklahoma Department of Human Services (DHS) and OCA are the entities to which reports are submitted. Within DHS, two divisions are responsible for receipt, evaluation and response to critical incidents. The divisions responsible are Child Welfare Services (CWS)(maltreatment of children) and Developmental Disabilities Services (DDS) (incidents identified in Appendix G-1-a that do not constitute maltreatment). Office of Client Advocacy (OCA) investigates maltreatment of children in out of home living arrangements other than foster care as well as maltreatment of vulnerable adults by caregivers who have entered into Agreements with DHS.

CWS and OCA report their findings related to abuse, neglect, and exploitation of any member to DDS. Provider agencies are required by policy to report critical incidents, immediately, to the DDS, using the approved format. Further, to promote good communication, coordination of services and to ensure the health and welfare of members, DHS routinely conducts case staffings to address significant member issues such as abuse, neglect or exploitation. Multiple DHS divisions are commonly represented at case staffings and, assigned CPS workers for member's in the custody of the DHS, are members of the Personal Support Team.

Oversight activities are continuous and ongoing. Issues related to abuse, neglect, and exploitation or member health and safety are first addressed individually for immediate resolution. Critical incident information from all sources is entered into a database. On a monthly basis, the database information is compiled into various reports and provided to the DDS Incident Management Committee for analysis, to identify trends, and make recommendations. In the event the Incident Management Committee notices a trend or pattern of multiple incidents, the member would be monitored closely and individual intervention initiated if necessary. Individual intervention is used to prevent recurrence of critical incidents or events. When patterns are identified, policy and training changes occur. A web-based system for reporting and managing critical incidents is used.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** (Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

- ☒ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

- ☐ **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Individual Planning policies include a foundation for planning individual, person-centered services and supports which emphasize positive approaches aimed at skill enhancement and make use of the least intrusive and least restrictive options. The planning process includes individual assessment that identifies the member's needs and choices for supports and services related to personal relationships, home, employment, education, transportation, health, safety, leisure, social skills, and communication. There is also a focus on early intervention and prevention by the Team when changes occur and assessing and addressing areas in which the member's safety is at risk including physical, emotional, medical, financial, or legal risks or risks to community participation. When behavioral risks are identified, the member's Individual Plan (Plan) must include protective intervention planning which describes the preventive supports, services, and actions to be taken to reduce or eliminate risks. This includes, as needed, identifying requirements or changes in the member's environment, program and service requirements, instruction and procedures to be used by staff or Team members during a situation that places the safety of the member or others at risk, education components, staff training requirements, and methods and timelines to evaluate the effectiveness of the Plan.

If the member's Team determines that personal restraint, drugs used as restraints or mechanical restraints are essential for safety because of challenging behaviors that create risk of physical injury or harm to the member or others, risk of involvement in civil or criminal processes, or places at serious risk the member's physical safety, environment, relationships, or community participation, a Functional Assessment must be completed and Protective Intervention Protocol(PIP) developed and overseen by the member's Team and an appropriately licensed professional or family trainer. The Functional Assessment must include sufficient justification for the use of the restraint and the PIP must include instructions to staff on positive, pro-active steps to prevent incidents from occurring, how to calm the member during dangerous or disruptive episodes, how and when to take appropriate action to protect the member, staff, and others when the member's behavior is dangerous, who to call for assistance when necessary and ways to prevent the misuse of the restraint procedures. The Functional Assessment must also include fading criteria for the reduction and/or elimination of the restraint.

Use of restraint procedures is regulated by OAC 340:100-5-26, OAC 340:100-5-26.1, and OAC 340:100-5-51 through 40:100-5-58. Seclusion and facedown physical restraint are prohibited. Mechanical restraints are prohibited except when absolutely necessary to promote healing or prevent injury during or following a medical procedure. Medical mechanical restraints are prescribed by a physician.

A physical management hold per OAC 340:100-5-57, is used only to prevent physical injury. Any protective intervention protocol that includes a physical hold component requires the Team to discuss with the member's physician whether the member has any health concerns related to its use and include in the planning sessions a trainer of physical management procedures. The trainer makes recommendations about the effectiveness and safety of using a physical hold in particular environments; assists the Team in identifying alternative approaches when standard procedures do not appear appropriate for the member or the situation; and identifies existing physical obstacles to the implementation of a procedure for particular staff. The team includes the trainer's recommendations, identifying any situation in which a physical hold cannot be used as such use would be unsafe or ineffective.

Personal restraint is used only to prevent physical injury and ensure physical safety. Any use of restraint not included in a PIP is considered an emergency intervention. Emergency intervention is used for no longer than is necessary to eliminate the clear and present danger of serious physical harm to the member or others. Personal restraint must be terminated as soon as the person is calm or the threat has ended and release must be attempted every two minutes. When responding to an emergency, the amount of force can never exceed that which is reasonable and necessary under the circumstances to protect the person or others. An incident report must be completed and submitted to the DHS/DDS Case Manager for Team review within one business day.

After the first use of an emergency restraint procedure, if the Team determines that the use of the procedure must be continued to ensure the safety of the member or others, the DDS Director of Psychological and Behavioral Supports or designee may provide temporary immediate approval of continued use of restrictive or intrusive procedures. Temporary approval of use of emergency interventions lasts no longer than 60 days. The request must provide sufficient information to demonstrate that positive supports were attempted, and the danger of severe harm still exists. At a minimum, required information includes all incident reports from

the last three months with details on the harm caused and other indications of severity as well as a description of existing positive supports and services. To continue using the temporarily approved procedure, the Team must submit a PIP that incorporates the requested procedures to the Statewide Human Rights and Behavior Review Committee (SHRBRC). If the submitted PIP does not receive committee approval, the committee may extend the temporary approval if the committee determines that conditions warrant extension for a maximum of 45 additional days. The Case Manager reviews the incident reports and ensures the Team meets within five business days of the review.

Completion of an approved behavior support course is required for direct support staff serving persons with PIP's that include physical restraint to restrict movement. Staff must also complete an approved physical management course before using any technique of physical management contained in a PIP. Only staff and their supervisors who provide support to the member are trained on the use of a physical management procedure. Staff who have been formally trained to use physical management procedures do not use those techniques with other members, except in emergencies as defined in OAC 340:100-5-57. Staff must complete an annual retraining on the specific physical management procedures in the PIP. The Team must submit each behavioral protective intervention protocol containing restraints to the Statewide Human Rights and Behavior Review Committee per OAC 340:100-3-14. The committee is established to review each behavioral PIP with restrictive or intrusive procedures. Members are appointed by the Director of DDS. The committee includes at least three professional members with expertise in areas relating to the duties of the committee including: positive behavior supports and educational methodologies; issues involving human rights; and related medical or psychiatric issues. Other members include at least two individuals who receive DDS services or are a family member, Guardian, or Advocate of a member.

The committee ensures that each PIP complies with requirements found in OAC 340:100-5-57 and that the PIP focuses on: prevention; education; skill development; staff training and conduct; and other positive approaches. Whenever restrictive or intrusive procedures are requested, the committee ensures: that due process is afforded; the restrictive or intrusive procedure is the least restrictive alternative; and that educational procedures are in place to assist the member in restoring the restricted right(s). The committee is the final approval authority for PIP's that include a restrictive or intrusive procedure(s). The committee sends a copy of the PIP review summary to the DHS/DDS Case Manager. The review summary specifies whether the PIP is:

- approved;

- conditionally approved, with required information or changes to be provided within a time period specified by the committee; or

- not approved, with required information or changes to be provided within a time period specified by the committee. The DHS/DDS Case Manager convenes the Team within ten days of receipt of the committee minutes and summary for review and necessary modifications to the PIP.

PIP's must be modified to accommodate the recommendations of the committee and approved prior to implementing the proposed restrictive or intrusive procedure(s). Approval is for no longer than one year and must be renewed annually as long as the restrictive or intrusive procedure is in place.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DHS/DDS oversight activities relating to restraints are ongoing.

When a restraint procedure is used, an Incident Report is prepared by the person of the provider agency who initiated the procedure in accordance with OAC 340:100-5-57.1. The Incident Report includes, at a minimum, a description of: the circumstances leading to the use of the intrusive procedure(s) or emergency intervention(s), including all procedures attempted prior to using the intrusive procedure or emergency intervention; the intrusive procedure or emergency intervention procedure(s) used; and the outcome of the incident, including any physical harm or damage caused.

Provider agency program coordination staff review the Incident Report and complete a written review which indicates whether: the intrusive procedure(s) was implemented according to the PIP or the emergency intervention(s); the intervention complied with the requirements of subsection (f) of OAC 340:100-5057; the use of intrusive procedure(s) or emergency intervention was reasonable and necessary; and includes recommendations and a description of actions taken. The service provider ensures the incident report is submitted electronically to DDS.

The DHS/DDS Case Manager ensures the Team, as described in Appendix D-1:c, meets within five business days of review of the Incident Report documenting use of physical management or emergency intervention. The Team, as described in Appendix D-1:c, reviews the particulars of the incident to ensure use was reasonable and the least restrictive alternative available. The Team, as described in Appendix D-1:c, takes necessary action to address any identified issues, describes any systems concerns, addresses any further recommendations, and/or planned interventions.

A data base captures information related to the use of restrictive/intrusive procedures by member served, agency providing services, location of intervention and time of use. The DHS/DDS Director of Psychological and Behavioral Supports and the Positive Support Field Specialist review Incident Reports including highly restrictive procedures on a monthly basis. - If it appears that use of restrictive or intrusive procedures or emergency intervention has occurred in violation of policy requirements, approval for use of physical management or emergency intervention may be suspended by the DHS/DDS Director of Psychological and Behavioral Supports pending review by the SHRBRC in accordance with OAC 340:100-3-14.

- If abuse or neglect is suspected, the authorities charged by law with the investigation of alleged abuse are notified.

- The DHS/DDS Director of Psychological and Behavioral Supports may require additional staff training or supports.

- The Positive Support Field Specialist may provide assistance to the Team, as described in Appendix D-1:c.

- If significant issues of non-compliance with contract or policy requirements are noted, an Administrative Inquiry in accordance with OAC 340:100-3-27.1 may be requested.

In addition to review by the DHS/DDS Director of Psychological and Behavioral Supports, an Incident Management Committee reviews all critical incidents, including but not limited to, those involving the use of restraint procedures. The Committee meets regularly to review reports generated from a data base containing data collected from Incident Reports. The Committee is charged with analyzing the data to identify systems issues, trends, and patterns and makes findings and recommendations to support continuous quality improvement and prevent recurrence.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. (Select one):

- ☒ The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restrictive procedures are defined in DHS policy as those which result in the limitation of the member's rights including their communication with others, access to leisure activities, money or personal property, goods or services, movement at home or the community or any direct observational procedures specified as a result of challenging behavior during times or places which would otherwise be considered private. Use of restrictive procedures is regulated by OAC 340:100-5-50 through 340:100-5-58. Aversive conditioning procedures, withholding meals, breaks, sleep or the ability to maintain personal hygiene, involuntary forfeiture of money or personal property, corporal punishment and the use of exclusionary time-out or timeout rooms are all prohibited. The use of restrictive intervention must be reported via an incident report and critical incident reporting procedure followed. DHS/DDS Case Managers as well as the Incident Management Committee review cases to detect unauthorized use of restraint. DHS/DDS Case Managers and Quality Assurance monitoring is also in place to detect any unreported use of restraints.

The member's Team is required by policy to complete a risk assessment which identifies potential areas in which the member's safety is at risk, including physical, emotional, medical, financial, or legal risks, or risk to community participation. This assessment identifies the frequency and degree of potential harm to the member or others; and why, when, where, and how the risk to safety may occur. The Team identifies places, conditions, early signs or other indicators of potential safety risks. The Team also identifies the member's skills or lack thereof, which impact the safety risks. Such skills include communication skills, coping skills, social skills, leisure skills and vocational skills. The risk assessment takes into account the member's past experience, any medical, psychiatric or pharmacological issues, recent changes in the member's life and identification of previous supports which have been effective or ineffective in preventing or reducing the risks.

When risk or the potential for risk is present, the elements of the risk assessment must be addressed as part of a PIP. Policy requires that a PIP focus on positive, preventative supports and actions to reduce or eliminate safety risks. These positive supports include, but are not limited to: making changes in the member's environment; providing trained, consistent staffing and oversight of staff; ensuring adequate communication and coordination between Team members as well as adequate and appropriate communication with the member; providing the member with appropriate and meaningful daily activities and eliminating or managing medical, psychiatric or physical conditions which may be impacting risk. These positive supports are required to be developed based on the member's unique needs and used prior to any use of restrictive interventions.

When there is the possibility of imminent risk or dangerous behavior, temporary approval of the use of restrictive procedures for 60 days can be requested using form 06MP042E, while the Team develops a PIP. This form requires the Team to identify all less restrictive, positive approaches already attempted and to identify positive approaches which are to be attempted or explored prior to using a restrictive procedure during the 60 day approval period. These positive approaches, just like those in the previous paragraph, include addressing medical issues, restructuring the environment, skill development, improving communication, retraining staff, relationship building, etc.

Individual planning policies include a foundation for planning individual, person-centered services and supports which foster positive approaches aimed at skill enhancement and make use of the least intrusive and least restrictive options. The planning process includes individual assessment that identifies the member's needs and choices for supports and services related to personal relationships, home, employment, education, transportation, health, safety, leisure, social skills, and communication. There is also a focus on early intervention and prevention by the Team when changes occur and assessing and addressing areas in which the member's safety is at risk including physical, emotional, medical, financial, or legal risks or risks to community participation.

The Plan must include protective intervention planning which describes the preventive supports, services, and actions to be taken to reduce or eliminate risks. This includes, as needed, identifying requirements or changes in the member's environment, program and service requirements, instruction and procedures to be taken by staff or Team members during a situation that places the safety of the member or others at risk, education components, staff training requirements, and methods and timelines to evaluate the effectiveness of the plan. The PIP must treat the member with dignity and be reasonable, humane, practical, not controlling and the least restrictive alternative. If the Team determines that restrictive procedures are

essential for safety, the protective intervention planning must include sufficient justification for their use. The PIP must also explain documentation requirements for the use of restrictive procedures. An incident report is required for use of highly restrictive procedures including physical restraint and the use of PRN psychotropic medication. All incident reports are submitted to the DHS/DDS Case Manager and critical incident reports, which include those involving highly restrictive procedures, are also reviewed by DHS/DDS Director of Psychological and Behavioral Supports. Each behavioral PIP includes documentation requirements with instructions regarding how data will be captured on all elements of the protocol, including restrictive procedures. The protocol must be approved by the Statewide Human Rights and Behavior Review Committee.

Case Managers monitor the provision of services, including restrictive procedures, through observation, record review and provider incident and progress reports.

The Positive Support Field Specialists and Director of Psychological and Behavioral Supports review all critical incident reports involving the use of highly restrictive procedures on a monthly basis. The Director of Pharmacy Services reviews all critical incidents of prn medication administration for behavioral control on a monthly basis. DHS/DDS policy defines highly restrictive procedures as use of a prn medication for behavioral control and the use of a physical hold. Upon review of the monthly incident reports the Positive Support Field Specialist and Director of Psychological and Behavioral Supports takes further action, as needed, to ensure that requirements governing the use of restrictive/intrusive procedures are followed.

- Positive Support Field Specialist may provide assistance to the Team.

- If problems are noted, an DHS/DDS Quality Assurance Unit Administrative Inquiry in accordance with OAC 340:100-3-27.1 may be requested.

- If it appears that abuse or neglect has occurred, the authorities charged by law with the investigation of alleged abuse are notified.

Database information, as described in Appendix G-2-b.ii. is analyzed to identify trends and/or patterns related to increased use of restrictive/intrusive procedures by member, agency providing services, location of intervention(s), duration of restrictive/intrusive procedure(s) used including total time of physical restraint usage, and staff initiating the restrictive/intrusive procedure(s). Identified trends and/or patterns of usage will be addressed via specified improvement strategies, which may include additional training, monitoring, or oversight.

DHS/DDS Case Managers, who facilitate Team meetings, complete required training courses and in-service including training on rights issues, use of restrictive procedures and the process for approval of restrictive procedures. Direct support staff responsible for day-to-day implementation of restrictive procedures, and their supervisors, complete training which includes Foundation Training and individual-specific in-service on the PIP. Residential staff also complete a Residential Ethical and Legal training course. All staff complete the same basic training courses and are required to be trained on the individual-specific components of the PIP, which would include restraint/restrictive procedures. Provider staff complete an approved physical management course if physical management procedures are indicated in the approved PIP.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DHS/DDS is responsible for the oversight and monitoring of the use of restrictive interventions and for ensuring that safeguards are followed and in accordance with OAC 340:100-5-57.1.

An Incident Management Committee reviews critical incidents and other quality management reports including but not limited to those involving the use of restrictive or intrusive procedures. The Committee meets monthly and reviews reports generated from a database containing data collected from individual incident reports. The Committee is charged with analyzing the data to identify systems issues, trends, and patterns and makes findings and recommendations to support continuous quality improvement and prevent recurrence.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. (Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)

- **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The operating agency is responsible for detecting the unauthorized use of seclusion. Case Managers are responsible for ongoing monitoring of the health and welfare of the member. This is accomplished through review of quality progress reports and at least quarterly face-to-face contact with the member. Case Managers also review incident reports on an ongoing basis to detect unauthorized use of seclusion.

- **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ☒ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ☐ **Yes. This Appendix applies** *(complete the remaining items)*

• **Medication Management and Follow-Up**

Do not complete this section

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ☐ **Not applicable.** *(do not complete the remaining items)*
- ☐ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- **Medication Error Reporting.** *Select one of the following:*
 - ☐ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:
 - (a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

- Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of Critical Event Reports that identify abuse, neglect, or exploitation for which follow-up was completed by the team. Numerator: Number of Critical Event Reports that identify abuse, neglect, or exploitation for which follow-up was completed by the team. Denominator: Total number of Critical Event Reports that identify abuse, neglect, or exploitation.

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☒ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of unexplained deaths for which mortality reviews were completed in order to prevent future events. Numerator: Number of unexplained deaths for which mortality reviews were completed in order to prevent future events. Denominator: Total number of unexplained deaths.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports of Unexplained Deaths

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other	☐ Annually	☐ Stratified

Specify: 		Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☒ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of member's records reviewed where the member (or legal guardian) received information/education about how to identify and report abuse, neglect, exploitation. Numerator: Number of member's records reviewed where the member received information/education about how to identify and report abuse, neglect, exploitation. Denominator: Total number of member's records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of abuse, neglect, exploitation, and unexplained death events reviewed/investigated within the required timeframe. Numerator: Number of abuse, neglect, exploitation and unexplained death events reviewed/investigated within the required timeframe. Denominator: Total number of abuse, neglect, exploitation and unexplained death events.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☒ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:

	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☒ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of substantiated abuse, neglect, exploitation and unexplained death events where required/recommended follow-up was completed. Numerator: Number of substantiated abuse, neglect, exploitation, and unexplained death events where required/recommended follow-up was completed. Denominator: Total number of substantiated abuse, neglect, exploitation and unexplained death events.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☒ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☒ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☒ Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	☐ Continuously and Ongoing
	☐ Other Specify:

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of member's records reviewed for whom the provider completed required critical event reports. Numerator: Number of member's records reviewed for whom the provider completed required critical event reports. **Denominator:** Total number of member's records reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval =

		95% confidence level and +/- 5% margin or error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of critical events that were reviewed by the Event Management Committee to ensure proper action was taken to prevent further events. Numerator: Number of critical events that were reviewed by the Event Management Committee to ensure proper action was taken to prevent further events. **Denominator:** Total number of critical events.

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of medication errors that did not result in emergency medical treatment. Numerator: Number of medication errors that did not result in emergency medical treatment. **Denominator:** Total number of medication errors.

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☒ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:

	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of medication errors reviewed by case management staff as required by the State. Numerator: Number of medication errors reviewed by case management staff as required by the State. Denominator: Total number of medication errors.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify:	☐ Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of critical events that were reported within required timeframes as specified in the approved waiver. Numerator: Number of critical events that were reported within required timeframes as specified in the approved waiver.

Denominator: Total number of critical events.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☒ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

		☐
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of member records reviewed where the provider acted immediately to remedy any situation which posed a risk to the health, safety or provision of service. Numerator: Number of member records reviewed where the provider acted immediately to remedy any situation which posed a risk to the health, safety or provision of service. Denominator: Total number of member records reviewed.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):

☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☒ Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of critical events for which follow-up was completed by case management staff as required by the State. Numerator: Number of critical events for which follow-up was completed by case management staff as required by the State.

Denominator: Total number of critical events.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

		☐
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of medication errors where follow-up was completed as required to ensure resolution and prevention of future errors. Numerator: Number of medication errors where follow-up was completed as required to ensure resolution and prevention of future errors. Denominator: Total number of medication errors.

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review

☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☐ Annually
	☐ Continuously and Ongoing
	☐ Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify:

Performance Measure:

Number and percent of member's records reviewed where case management intervention occurred to address issues related to event reports and health and welfare risks. Numerator: Number of member's records reviewed where case management intervention occurred to address issues related to event reports and health and welfare risks. **Denominator:** Total number of member's records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

	☐ Other Specify: 	
--	---	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

- c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of member's records reviewed that were free from the use of prohibited behavior management procedures. Numerator: Number of member's records reviewed that were free from the use of prohibited behavior management procedures. Denominator: Total number of member's records reviewed.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of member records reviewed containing protective intervention protocols with restrictive procedures approved by the Statewide Behavior Review Committee. Numerator: Number of member records reviewed containing protective intervention protocols with restrictive procedures approved by the Statewide Behavior Review Committee. **Denominator:** Total number of member records reviewed.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval =

		95% confidence level and +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

- d. **Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

and percent of member records reviewed for whom the provider was required to identify a trained health care coordinator to ensure implementation and coordination of health care services. N: Number of member records reviewed for whom the provider was required to identify a trained health care coordinator to ensure implementation and coordination of health care services. Main B Optional

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Measures with a "critical events and incident reports" Data Source are pending full implementation of a web-based critical incident reporting system.

The data source for the proportionate representative sample is the Client Contact Manager, the system used to enter and maintain records on each active waiver participant. The sampling approach is less than 100% with 95% confidence level and a 5% margin of error.

A representative sample will be generated at the beginning of the waiver year. The sample will be divided as evenly as possible over the following four quarters. For each waiver participant included in the sample, record reviews will be conducted by DDS Quality Assurance survey staff for each survey question (performance measure) applicable to the individual.

Quality Assurance survey staff review the complete record of each individual in the sample to obtain the information needed to determine compliance with the performance measures in Appendix G. PM a.i.a.2 and a.i.b.5 are collected from the

Quality Assurance Operating Agency Monitoring survey tool. PMs a.i.b.1, a.i.b.3, a.i.c.1, a.i.c.2, a.i.d.2 are collected from the Quality Assurance Provider Performance survey tool. PMs a.i.a.5 and a.i.d.1 are collected from record reviews on site. The remainder of the performance measures are collected from the Incident Reporting database and reports run from the Client Contact Manager system.

Reference to "Q" numbers or numbers in the 1000-6,000 series in the Data Source field represent the DHS/DDS performance tool identifier.

Operating agency performance monitoring is based on a proportionate representative sample.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Follow-up on provider performance monitoring is completed by DHS/DDS Quality Assurance staff to ensure 100% correction. Follow-up survey documents are completed to verify correction. Provider agencies are required to correct deficiencies within 60 days. Failure to do so results in review by the DHS/DDS Performance Review Committee which may impose additional sanctions such as vendor hold. If, after sanctions and follow-up, a provider remains non-compliant, DHS/DDS recommends Agreement termination action to OHCA.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

OHCA strives to operate the waiver systematically incorporating the principles of continuous quality improvement. The Long Term Care Quality Initiatives Council (LTCQIC) collaborates for the trending, prioritizing and implementation of system improvement in OHCA waivers. The Council consists of various divisions within OHCA as well as provider agencies, advocacy groups and other stakeholders. The Council meets quarterly to discuss member and provider issues and to set priorities for system-wide quality improvement. The Council receives information from a variety of reports prepared by the OHCA's Long Term Services and Supports (LTSS) as well as provider agencies. As a result of an analysis of the discovery and remediation information presented to the council, system improvements are identified and design changes are made. Waiver reporting for the LTCQIC is stratified by the respective program. The Research Analyst and Senior Program Manager work with the Waiver Administration Director to ensure that data is reported accurately. Both member and provider data are compiled in accordance with the program as noted in the OHCA MMIS.

The LTCQIC annually reviews the Quality Oversight Plan and utilizes numerous quality indicators that are tracked and reported on an annual basis. The State aggregates, verifies, and analyzes the results of the discovery processes to evaluate the indicators for each sub-assurance. The State identifies trends, best practices, and areas for improvement. The LTCQIC develops recommendations for improvement strategies. Results can be communicated in various ways regarding systems improvements that have an impact to the public, interested parties, participants served in the waiver, or families. Notifications are communicated in one or more of the following methods: verbally at stakeholder meetings, letters mailed to participants, fax blast, web-site banners, provider letters and newspapers (depending on the nature of the change). The frequency of the results are communicated quarterly (when results are present, not every quarter are there suggestions for system improvements). In the case where system improvements are needed on an "emergent" basis, individuals are notified (in one of the above methods) once the error and solution has been identified.

Participants in the council represent a wide variety of stakeholders including but not limited to; LTSS staff, Care Management staff, Quality Assurance staff, Legal, Systems, DHS, and representatives of Member advocacy groups, and provider agency representatives.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☒ Quality Improvement Committee	☒ Annually
☐ Other Specify: 	☐ Other Specify:

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Oklahoma Quality Improvement Strategy weaves together various quality assurance and quality improvement activities using a three-tiered process. Tier 1 includes quality assurance processes that are implemented at the member/Case Manager/provider level. Tier 2 includes discovery and remediation processes implemented at the DHS/DDS Program Manager/OHCA Level of Care Evaluation Unit/DDS Quality Assurance Unit level. Tier 3 is the DDS State Office Division level and OHCA Medicaid Agency level and focuses on quality improvement at a systems level.

TIER 1: The first tier involves strategies to ensure members, advocates, guardians, teams, Case Managers and providers have the tools to develop, implement and monitor quality services. At this level, quality assurance and improvement happens with members on an ongoing basis and is designed to safeguard members.

TIER 2: The second tier involves DDS Program Managers, the OHCA Level of Care Evaluation Unit and the DDS Quality Assurance Unit as well as committees established to collect and analyze data and make program adjustments to improve service quality. At this level, the strategy is designed to collect and review data from Case Managers, providers, guardians, advocates, members and Teams on a wide variety of quality indicators and develop remediation and program improvement strategies to ensure that performance standards and assurances are met.

TIER 3: The third tier involves DDS State Office Executive staff and OHCA staff. DHS/DDS monitors non-licensed providers for compliance and provides results to OHCA.

The Area Survey monitoring process is a record review of the DHS/DDS Case Manager record, based on a statistically significant random sample of members receiving supports through the waiver. One quarter of the representative sample is monitored each quarter. This results in a complete representative sample being reviewed each year. The record reviews include a review of service plans to assure: all member needs are addressed and preferences considered; they are developed according to policy and updated/revised as needed ensuring an interim meeting was held within 30 days of identification or notification of the need for change in authorization of waiver services; services are delivered in accordance with the service plan including the type, scope, amount and frequency specified in the service plan; and that members are afforded choice between waiver services and institutional care and between/among waiver services and providers. The Area Survey record reviews provide a process for monitoring the health and welfare of members, assuring Case Managers: conduct face-to-face visits as required; address issues that could put the member's health or welfare at risk; and provide follow-up on issues identified in incident reports. The results of the Area Survey monitoring process are shared with OHCA. The data is reviewed to identify trends and areas for improvement. Recommendations are developed for systemic improvement.

The Performance Survey is an annual monitoring site visit in which all provider agencies participate, providing data based on an aggregated statistically significant sample of members receiving waiver services and an aggregated statistically significant sample of provider agency staff. The Performance Survey includes all waivers for which the provider agency contracts. Monitoring of service plan development and implementation includes: a review of provider agency records for a random sample of waiver members; and home visits and interviews with waiver members and other pertinent people, for those sampled. The annual monitoring of non-licensed/non-certified provider staff includes a review of personnel records for a sampling of staff assigned to provide supports, to ensure all required employment background checks have been obtained and all required training has taken place. The Performance Survey process provides for a sampling of financial records to ensure compliance with provider Agreements. DHS/DDS policy provides the expectation that all identified barriers to performance consistent with the expectation of regulatory policy and contracts are resolved no later than 60 days following the completion of the annual Performance Survey. Failure to correct identified barriers could result in administrative sanctions. The results of Performance Surveys are shared with OHCA. The data is reviewed to identify trends and areas for improvement. Recommendations are developed for systemic improvement.

DHS/DDS and OHCA review trends and data. Performance measures are developed or updated as needed. The State reviews results, tests new performance measures, analyzes and makes modifications as appropriate.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

DHS/DDS and OHCA review data gathered as a result of the Quality Improvement Strategy and look for trends. Areas needing improvement are identified and prioritized. Program staff respond to recommendations by designing and implementing improvements. Continued monitoring of performance measures identifies effectiveness of improvements.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

- ☐ No
- ☒ Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

- ☐ HCBS CAHPS Survey :
- ☒ NCI Survey :
- ☐ NCI AD Survey :
- ☐ Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The entity that is responsible for the independent audit under the Single Audit Act in Oklahoma is the Office of the State Auditor and Inspector. This agency performs annual audits separately and apart from the operating agency (DHS) and the Medicaid agency (OHCA.)

The DHS Office of Inspector General (DHS/OIG) is the Division within the Oklahoma Department of Human Services charged with the responsibility to investigate allegations of fraud, waste or abuse as well as other allegations of criminal activity against the Department or programs administered by the Department. DHS/OIG also has the responsibility to audit vendors and suppliers of Department goods and services under the Federal Single Audit Act of 1984, as well as Divisions and Units of the DHS for program compliance and performance. Compliance with the Single Audit Act of 1984 is ensured by the review of independent audit reports for the subrecipients of federal funds. A listing is maintained of audits required. Deficiencies requiring revision by the independent auditor and corrective action plans needed for subrecipients are monitored and resolved.

DHS requires all non-licensed and group home providers who receive payments of \$100,000 or more per year to submit a certified independent audit of its operations conducted in accordance with Government Auditing Standards. No other provider types are required to submit an independent audit. These audits are required annually and are due 120 days from the providers fiscal year end. The financial statements are to be prepared in accordance with Generally Accepted Accounting Principles and the report includes a Supplementary Schedule of Awards listing all State and Federal funds by contract Agreement. DHS/DDS staff reviews these audits and follow-up on any findings relative to waiver programs. In addition, service providers participate in provider performance monitoring at least once each year by the OKDHS/DDS Quality Assurance Unit, who review documentation related to service delivery to confirm billed charges on a random sample. The samples are statistically valid with a 95% confidence level and a +/- 5% margin of error.

Effective July 1, 2020, all providers of Personal Care services to members receiving Habilitation Training Specialist and/or Self-Directed Habilitation Training Specialist services must use Electronic Visit Verification (EVV) to document provision of these services. When these services are provided in a congregate setting where 24-hour service is available, or when respite is provided outside the member's home, EVV is not required. Effective January 1, 2024, all providers of Home Health services are required to use an EVV system as validation the service was provided. Oklahoma has elected to use a single EVV system as the aggregator. Other EVV compliant systems may be used, but data must be submitted to the aggregator. Procedure codes for services requiring EVV will be flagged by the State Medicaid Agency. Claims for the services that require EVV will be denied unless the claim has been submitted by the aggregator. Quality Assurance will audit EVV claims annually as part of their provider performance surveys. The scope of the audits of the claims are to review documentation related to service delivery to confirm billed charges, to ensure the EVV system is being used as required and to ensure that providers are complying with the EVV policies and procedures. The State utilizes the random sampling method. To ensure the samples are statistically valid, the State uses a 95% confidence level and a +/-5% margin of error. Audits do not differ, in any way, by service or provider. The State does not require providers to provide corrective action plans when problems are identified with claims. The State requires payback if there are errors in provider claims. DDS Quality Assurance staff completes a 60-day follow-up audit to ensure there are no other issues with claims and that the provider corrected the billing on the identified error(s).

The Program Integrity and Accountability Unit is the unit within OHCA responsible for program audits. This unit has departments which conduct provider audits: Clinical Provider Audits and Data Analytics (DA). Audits conducted by each department vary slightly in how the audits are completed. DA conducts audits based on specific errors identified through data analysis with identified overpayments based on these errors. For example, annually DA identifies claims billed for home and community-based services (case management, personal care, nursing, adult day center, etc.) if the member was institutionalized or hospitalized. In this example, all services billed while a member was institutionalized or hospitalized is identified as errors and applicable overpayment is determined. In contrast, Clinical Provider Audits investigates all internal or external referrals and uses exception processing and peer-to-peer comparisons to identify and initiate audits which may result in having an audit opened.

When an audit is opened by Clinical Provider Audits, a comprehensive clinical audit with records review is completed. The audit scope, review period, and review type are determined by the Case Selection Committee.

Audit scope may be a universe or statistical sample based on the concerns identified. When statistical sampling is used, the samples are statistically valid by using a 95% confidence level with a +/- 5% confidence interval. The review periods vary based on the allegation and/or risks identified. The review period may range from three months to two years. Records are collected either by desk (mailed records request) or onsite audit (announced or unannounced onsite collection by the designated audit team). When reviewing allegations/complaints and/or data mining, providers may rise to a higher level of risk which would warrant an onsite audit. The most common reason to conduct an onsite audit is that there is reason to

suspect that the provider may create or alter records if given advance notice. Another common reason to conduct an onsite audit is when it is expected that the audit will result in a credible allegation of fraud, then an onsite audit is typically performed.

Once the audit is assigned, data is compiled, preliminary research is completed, and the records are received, the comprehensive audit of records is completed. Comprehensive clinical audits results in a complete review of medical, clinical, and service records along with appropriate supporting documentation to validate that services were medically necessary, policy compliant, and performed by appropriate personnel for an eligible member. When errors are identified, the claim line is recoupable with the appropriate overpayment identified. In accordance with Oklahoma Administrative Code (O.A.C.) 317:30-3-2.1, if the error rate is 10% or greater, extrapolation is utilized to determine the final identified overpayment amount. Corrective action plans are not utilized by Program Integrity. Instead, these are financial audits that result in recoupable findings with associated overpayments.

Errors in provider claims may include (1) claims payment without corresponding documentation of service delivery and (2) claims payment in excess of service plan authorization. Claims error occurrence will be measured for each member and in summary of all members reviewed. Measures of claims error occurrence are (1) percent of units paid without service delivery documentation in the period and (2) percent of units paid in excess of authorized units in the period.

A Provider rate increase was applied to the following services as approved by the state for WY 3-5:

A Provider rate increase of 25% was applied to Habilitation Training Specialist Services and Self-Directed Habilitation Training Specialist Services as approved by the state for WY 3-5.

A Provider rate increase of 10% rate increase was applied to Prevocational, Respite, Supported Employment - Individual, Supported Employment - Group, Respite Daily - In Home, and Respite Daily - Out of Home services as approved by the state for WY 3-5.

Appendix J estimates for WY3 include only 75% of the annual rate increase amount since the requested effective date is October 1, 2024.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of claims with payment errors which were remediated in

accordance with OHCA policy following error identification through provider performance review. Numerator: Number of claims with payment errors which were remediated in accordance with OHCA policy following error identification through provider performance review. Denominator: Total number of claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Claims Records

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of reviewed waiver claims submitted for Federal Financial Participation (FFP) that are specified in the member's service plan. Numerator: Number of reviewed waiver claims submitted for Federal Financial Participation that are specified in the member's service plan. Denominator: Total number of reviewed waiver claims submitted for Federal Financial Participation.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
☐ Other	☒ Annually	☐ Stratified

Specify: 		Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☒ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☒ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of service claims that were submitted for members who were enrolled in the waiver on the date that the service was delivered. Numerator: Number of service claims that were submitted for members who were enrolled in the waiver on the date that the service was delivered. Denominator: Total number of service claims.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Claims records

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☒ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify:	☒ Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of claims coded and paid in accordance with waiver reimbursement methodology specified in the approved waiver and only for services rendered.

Numerator: Number of claims coded and paid in accordance with waiver reimbursement methodology specified in the approved waiver and only for services rendered.

Denominator: Total number of claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS/Dss Query, Provider Audits

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☒ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

		☐
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of denied waiver claims from MMIS edit checks performed to determine whether the submitted waiver claims were authorized in the member service plan. Numerator: Number of denied waiver claims from MMIS edit checks performed to determine whether the submitted waiver claims were authorized in the member service plan. Denominator: Total number of denied waiver claims.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

MMIS claims data

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☒ 100% Review

☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of provider rates that remain consistent with the approved rate methodology through the five year waiver cycle. Numerator: Number of provider rates that remain consistent with the approved rate methodology through the five year waiver cycle. Denominator: Total number of provider rates.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☒ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:

	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of provider rates that followed correct rate methodology.

Numerator: Number of provider rates that followed correct rate methodology.

Denominator: Total number of provider rates.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☒ 100% Review

☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Reference to "Q" number or numbers in the 1000-6000 series in the Data Source field represent the OKDHS/DDSD performance tool identifier.

Operating agency performance monitoring is based on a proportionate representative sample. The data source for the proportionate representative sample is the Client Contact Manager, the system used to enter and maintain records on each active waiver participant. The sampling approach is less than 100% with 95% confidence level and a 5% margin or error.

A representative sample will be generated at the beginning of the waiver year. The sample will be divided as evenly as possible over the following four quarters. For each waiver participant included in the sample, record reviews will be conducted by DDS Quality Assurance survey staff for each survey question (performance measure) applicable to the individual.

Quality Assurance survey staff review the complete record of each individual in the sample to obtain the information needed to determine compliance with the performance measures in Appendix I. Performance measures a.i.a.1 and a.i.a.2 are sampled at less than 100% and the data is collected from the Provider Performance Monitoring Tool. The remainder of the performance measures are collected from financial records, provider audits, and claims records and are checked at 100%.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Follow-up on operating agency performance monitoring is completed by DHS/DDS program staff quarterly to ensure 100% correction of identified problems. Program staff maintain documents to verify correction.

Follow-up on provider performance monitoring is completed by DHS/DDS Quality Assurance Unit staff to ensure 100% correction. Follow-up survey documents are completed to verify correction. Provider agencies are required to correct deficiencies within 60 days. Failure to do so results in review by the DHS/DDS Performance Review Committee which may impose additional sanctions such as vendor hold. Program leadership follows up on issues identified in Quality Assurance provider performance evaluations. Program leadership also addresses member complaints. When trends are noted with specific provider agencies, program leadership directs meetings with the agencies to encourage remediation of all identified issues.

OHCA identifies individual problems during provider audits and in responding to member complaints filed through the Member Inquiry System. Setting quality improvement priorities and development of specific strategies to address quality issues are informed not only by internal discovery and monitoring; but, in addition, by interaction and recommendations from the LTCQIC. Providers identified for remediation must meet performance standards of the Conditions of Provider Participation in order to remain waiver providers. Providers who are under corrective action are given a time period in which improvements must be accomplished. These providers are monitored to ensure they achieve full compliance with standards. Ultimately, OHCA provider agreements can be terminated for failure to meet contractual standards. If, after sanctions and follow-up, a provider remains non-compliant, DHS/DDS recommends Agreement termination action to OHCA.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☒ **No**

☐ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rates are determined according to Oklahoma Statutes Title 74. State Government The Central Purchasing Act. 74 O.S. §85.7 Competitive bid or proposal procedures. A.11.a,b,c and d. The Oklahoma Central Purchasing Act may be found at the following link: <https://omes.ok.gov/services/purchasing/reference-guide/oklahoma-central-purchasing-act>. The OHCA State Plan Amendment Rate Committee (SPARC) is responsible for reviewing and setting all service rates for Medicaid services. The Oklahoma Health Care Authority solicits public comments on rate determination methods. This process is explained at Main Section 6-I. Rates are given final consideration and approval by the OHCA Board.

Rates were last rebased and reviewed in 2015. The state is in the process of conducting a rate study which is expected to be completed by January 2023.

Rates for waiver services are set by one of the methodologies below.

1)Method One - Fixed and Uniform Rate: Title 74 of the Oklahoma Statutes provides a methodology for setting fixed and uniform rates.

a. Determination of need for a fixed and uniform rate

- i. New: A new service is developed, or
- ii. Existing Service: Feedback from providers, clients, or the general public indicates that the existing rate is not sufficient to ensure access to an existing service.

b. Preparation of a Rates and Standards Brief:

i. Preparation: Staff prepares a position paper that at a minimum includes a description of the service, the payment history

including rates and utilization, the methodology utilized to arrive at the proposed rate, and a description of the funding source.

ii. Public Hearing: A public hearing notice is prepared and a hearing is scheduled.

iii. Oklahoma Office of Central Services: Copies of the public hearing notice, the Rates and Standards Brief and any other pertinent data is delivered to the Oklahoma Office of Central Services at least 30 days before the date of the public hearing. The Director of the Department of Central Services shall communicate any observation, reservation, criticism or recommendation to the agency, either in person at the time of the hearing or in writing delivered to the State agency before or at the time of the hearing.

c. Public Hearing Notice: Notice of public hearing will be provided in the following:

- i. Posted in the office of the Secretary of State
- ii. Posted by the Oklahoma Health Care Authority at its physical location and on the web site calendar
- iii. Published by the Oklahoma Health Care Authority in various newspaper publications across Oklahoma

d. Public Hearing:

i. Committee: The public hearing is conducted by the Rates and Standards Committee of the Oklahoma Health Care Authority. The committee is comprised of staff from the OHCA and DHS.

ii. Public comment: All attendees of the public hearing are offered an opportunity to voice their opposition or approval of the proposed rates, as described in Main Section 6-I. All comments become part of the permanent minutes of the hearing.

e. Final Approval: The rate is then scheduled for consideration and approval by the Board of Directors of the OHCA prior to implementation.

Services utilizing the Fixed Rate are:

- » *Habilitation Training Specialist*
- » *Occupational and Physical Therapy*
- » *Respite*
- » *Respite Daily*
- » *Specialized Medical Supplies and Assistive Technology***
- » *Prevocational**
- » *Supported Employment****

All fixed rates established by operating agency received the 4% increase. Appendix J reflects the cost estimate with the rate going in to effect October 1, 2019. If service utilization is distributed equally throughout the year only 75% of services would receive the increase. Services provided July through September would be at the original rates October through June would reflect the rate increase of 4%. Services not receiving the increase are those services that are based on Medicare or State Medicaid Rates or are manually priced.

2) *Method Two - Individual Rate:* Certain services, because of their variables, do not lend themselves to a fixed and uniform rate. Payment for these services is made on an individual basis following a uniform process approved by the Medicaid Agency. Services using this methodology are:

» *Family Training - Reimbursement made based on rate approved by DHS/DDS after evaluation of provider proposal and rate*

comparison process, not to exceed limits established at OAC 317:30-5-412.

» *Environmental Accessibility Adaptations and Architectural Modification - Methodology for these rates varies for different providers according to actual provider specialty. Providers may include Architects, Electricians, Engineers, Mechanical Contractors, Plumbers, Re-modelers and Builders. Further, each required environmental modification is different. For example, ramps costs (due to the initial conditions of the home and yard) differ according to such variables as the length of the ramp, types of rails, and strength of the ramp needed if, for instance the member has an electric wheelchair.*

The State requires three bids based on specifications in the scope of work. There are no set rates for these services as the State utilizes a bidding process to determine the vendor based on the ability to meet the member needs taking into consideration cost, completion time and contract with the State.

Environmental Accessibility Adaptations and Architectural Modification services are limited by the annual overall plan of care limit. The annual limit may be increased when services were ordered under a previous year's plan but not delivered or completed until the current plan of care year. In that case, the current plan of care may exceed the annual limit by the cost of the previously authorized Environmental Accessibility or Architectural Modification service. The annual limit may also be authorized to allow for major expenses in excess of \$2,500 of Environmental Accessibility Adaptations or Arch Mod services, combined with Assistive Technology, but not to exceed a combination of \$22,500.00 in any 5-year period.

» *Self-Directed Goods and Services - The rate for Self-Directed Goods and Services is based on a cost estimate from a vendor in the community.*

» *Self Directed Habilitation Training Specialist (SD-HTS) - The employer of record develops a rate, modeled on the provider managed rate, which does not exceed the overall cost limit of this waiver when combined with all other services on the plan of care.*

** Consistent with the approach to reimbursement for prevocational services approved by CMS in 1995, Oklahoma will continue to reimburse for prevocational services based per hour of participation (control number 0234.90.01). For individuals requiring enhanced supports, a differential rate is available.*

*** Oklahoma Health Care Authority has an established pricing methodology for Specialized Medical Supplies and Assistive Technology that do not have fixed rates. Rates are determined using SoonerCare reimbursement methodology or individual rate. Assistive Technology services are authorized by selecting the best bid from among a minimum of three when the cost exceeds \$5000.00 and the item does not have a fixed Medicaid rate. If the item is not available under the SoonerCare State Plan, but the item is essential to the member's health and/or safety, the item may be authorized through*

the waiver.

*** Consistent with the approach to reimbursement for supported employment services approved by CMS in 1995, Oklahoma will continue to reimburse for job coaching and stabilization based on hours worked (control number 0234.90.01). Individual placement in job coaching services require the on-site provision of supports by a job coach for more than 20% of the individual's compensable hours. Stabilization services require the on-site provision of supports by a job coach for 20% or less of the individual's compensative hours. A differential rate is available for individuals requiring enhanced supports.

Effective October 1, 2019, an across the board 4% rate increase was applied to all rates established by the operating agency. The remaining 1% of the increase was applied in year 5.

Payment rates are available to members on the OHCA web site. Notice of Authorization statements, which include service rates, are automatically mailed to members via an electronic authorization system when authorizations are issued or updated. In addition, a master list of all waiver services, with correlating HCPC code and rate, is available for viewing on the OKDHS web site.

Every three years, the Oklahoma Health Care Authority completes an Access Monitoring Review Plan. The OHCA is committed to continuous quality improvement with respect to services and beneficiaries, while maintain an extensive provider base. Since the Agency's first AMRP, OHCA continues to focus on access to care for its members by establishing new services and rate increases for providers. In general, unless noted by policy change, most year-to-year fluctuations in provider counts are from temporary decreases due to contract renewal periods, especially in regards to out-of-state providers, or it's due to changes in the methodology of how provider types and specialties are counted.

All rates are taken to a public Tribal Consultation, a public rate hearing, a public notice, and taken to a public OHCA Board meeting. Feedback is taken from providers on rates and rate methods. Additionally, the OHCA's Member and Provider Services Unit take calls from members and providers when there are access issues. If there is a continual problem with rates, rate methods can be changed accordingly based on the feedback. Also, care managers speak directly with members and can locate resources if they are having difficulty gaining access to services.

Further, the AMRP demonstrates the Agency's compliance with 1902(a)(30)(A) of the SSA, which assures state payments are consistent with efficiency, economy, and quality of care sufficient to enlist enough providers so that services under the State Plan are available to beneficiaries at least to the extent that those services are available to the general public.

Respite Services:

The rate setting methodology for respite services was reviewed in May 2018. At that time, daily respite services had mirrored the setting rate for agency companion services, specialized foster care, and group home services. The rate was not sufficient to cover the member's room and board costs, so we calculated a rate that was 90% of the SSI payment for a single individual. Respite Daily in-home and Respite hourly rates do not include room and board.

The state does not expect the telehealth service delivery option to have an impact on rates for this service, as such, the state is not updating its rate methodology for Family Training services.

During May 2022, the Oklahoma Legislature appropriated funding to DHS to fund a waiver provider rate increase. Effective 10-01-22, the following services will receive a 25% increase:

Habilitation Training Specialist Services
 Prevocational Services
 Respite
 Occupational and Physical Therapy Services
 Supported Employment
 Respite Daily

(Continued in section Main B.)

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from

providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims for waiver services are submitted by providers directly to and are processed by Oklahoma CMS-certified Medicaid Management Information System (MMIS) and are subject to all validation procedures included in the MMIS. All claims for waiver services must be matched to an active prior authorization. Prior authorizations are created from the waiver member's individual plan of care.

All claims processed through the MMIS are subject to post-payment validation including, but not limited to SURS. When problems with service validation are identified on a post-payment review, erroneous or invalidated claims are voided from the claims payment system and the previous payment are recouped from the provider.

The State has been compliant with the use of EVV within the fiscal integrity system since January 1, 2021.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

- ☒ No. state or local government agencies do not certify expenditures for waiver services.
- ☐ Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

- ☐ Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

- ☐ Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Claims for waiver services are processed by Oklahoma's CMS-certified MMIS and are subject to all validation procedures included in the MMIS. This ensures that payments are made only when:

- (a) All claims for waiver members are first validated for member eligibility according to data contained in the MMIS.
- (b) All claims for waiver services must be matched to an active prior authorization. Prior authorizations are created from the waiver members individual plan of care with provider of service, dates of authorization and units as specified in the service plan. Claims processing edits built into the MMIS deny claims payment if any of the following conditions are encountered:
- Date of service is outside member eligibility dates;
 - Service provided is outside the benefit package for the waiver;
 - Provider is not a qualified provider;
 - Service is not prior authorized;
 - Units are in excess of prior authorized;
 - Date of service is outside prior authorization.
- (c) All claims processed through the MMIS are subject to post-payment validation including, but not limited to Program Integrity and Accountability. When problems with service validation are identified on a post payment review, erroneous or invalidated claims are voided from the claims payment system and the previous payments are recouped from the provider. Provider audits review service delivery in comparison with claims and service plan authorization. If the provider audit detects a pattern of inappropriate billing, a referral is made to OHCA Program Integrity and Accountability for review and further investigation of the provider's billing practices. Identified overpayments are reported quarterly on Form CMS-64 to return the Federal share of the inappropriate claims. DDS Case Managers assure that freedom of choice among providers and services are offered to each member. A freedom of choice form is signed by the member or his/her Guardian.

Effective July 1, 2020 all providers of Personal Care services must use Electronic Visit Verification (EVV) to document provision of these services. Effective January 1, 2024, all providers of Home Health services are required to use an EVV system as validation the service was provided. Procedure codes for services requiring EVV will be flagged by the State Medicaid Agency. Claims for the services that require EVV will be denied unless the claim has been submitted by the aggregator.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (select one):

- ☒ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ☐ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☒ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- ☐ **No. The state does not make supplemental or enhanced payments for waiver services.**
- ☒ **Yes. The state makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

One-time supplemental payments are available to 1) support salary enhancements for recruitment and retention of Direct Support Professionals (DSP) 2) provide reimbursement of the employer's share of payroll taxes and 3) provide incentives to participate in the program.

These payments will be made to any provider employing Direct Support Professionals providing care to persons receiving HCBS waiver services.

The source of non-Federal funding is state dollar appropriations.

The providers receiving the payment retain 100% of the supplemental payment conditional on payment of incentives to their employees and associated employer payroll taxes.

The total cost of the one-time supplemental payment for this waiver is \$200,000. The state share is approximately \$61,940.

The supplemental payments are made available to direct support professionals (paraprofessional staff) who provide these waiver services: Habilitation Training Specialist Services (HTS).

All providers with this category of employee are eligible pending their registration and agreement to provide data, verify employment and facilitate payment transfer to their employees. Providers of waiver funded HTS services to In Home Supports Waiver for Children members are all eligible.

The DSP Allowability was introduced to Oklahoma's stakeholders through the Long Term Quality Initiatives Council and through our State Plan Amendment Rate Committee public comment. The payments will be posted via the OHCA and OKDHS website for public facing information.

The supplemental payments are made available to direct support professionals (paraprofessional staff) who provide these waiver services: Supported Employment and Prevocational Services.

All providers with this category of employee are eligible pending their registration and agreement to provide data, verify employment and facilitate payment transfer to their employees. Providers of waiver funded Supported Employment and Prevocational Services to In Home Supports Waiver for Children members are all eligible. Providers of self-directed HTS are also eligible pending their registration and agreement to provide data.

These payments will be made to any self-directed DSP or provider employing Direct Support Professionals providing care to persons receiving HCBS waiver services.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

- ☒ **No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.**

- **Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.**

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

- ☒ **No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ☐ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

- ☐ **No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.**
- ☒ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) DHS/DDS is considered a qualified OHCDS as the agency directly provides Targeted Case Management services utilizing its own employees. (b) Providers will be given the opportunity to enter into a SoonerCare Provider Agreement when they don't voluntarily agree to contract with a designated OHCDS. (c) Members who choose to self direct may choose any qualified provider that has contracted with the OHCDS or has entered into an agreement with OHCA, the State's Medicaid agency. (d) The member who chooses the self direction option and the FMS subagent will assure that all criminal background checks are completed on all prospective Habilitation Training Specialists and that all mandatory training requirements have been met. The member and the FMS subagent will be responsible to maintain copies of the documentation in the employee's file as required by DHS/DDS and OHCA. (e) DHS/DDS will function as the OHCDS and enter into a contract agreement with OHCA. (f) The FMS subagent will be required to be bonded and/or have sufficient liability insurance to protect members and the State against loss of funds, fraud or mismanagement. The FMS subagent is required to provide an annual audit as well as monthly reports.

iii. Contracts with MCOs, PIHPs or PAHPs.

- ☒ **The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ☐ **The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

- ☐ **Appropriation of State Tax Revenues to the State Medicaid Agency**
- ☒ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

State share funding for services provided under all of Oklahoma's Home and Community-Based Services (HCBS) Waiver programs is from general fund appropriations from the State Legislature made to two State agencies. The Oklahoma Department of Human Services (DHS) is responsible for providing State share funding for all waiver services except prescription drugs in excess of State Plan coverage limits and receives Legislative appropriations to cover the same. The Oklahoma Health Care Authority (OHCA) is responsible for providing State share funding for prescription drugs covered under the various waivers and receives Legislative appropriations to cover the same.

On a weekly basis, the OHCA submits a billing to DHS for the State share dollars for all waiver services (except prescription drugs) for which provider claims were processed/paid. Through an inter-agency transfer, these State share funds are then deposited into the OHCA's general fund. The transfer of these funds represents a repayment to the OHCA since the OHCA has already paid all provider service claims "in full".

All funding for State share costs of HCBS waiver services in Oklahoma is through Legislative appropriations. There is no funding of State share costs for waiver services using State or local funds from Certified Public Expenditures (CPEs), provider taxes or any other resource.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

☐ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

- ☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ☐ **The following source(s) are used**

Check each that applies:

- ☐ **Health care-related taxes or fees**
- ☐ **Provider-related donations**
- ☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

- ☐ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ☒ **As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Fixed rates for these services do not include any margin for room and board related expenses. Service provider Agreements specify that room and board expenses must be covered from sources other than SoonerCare such as client fees, donations, fund raising, or State funded programs. Providers of waiver services are contractually prohibited from billing for room and board expenses through SoonerCare. Room and board costs for an individual while in an out of home respite setting are included in the Respite Daily rate. Respite Daily In Home services, in the member's own private residence, do not include room and board related expenses. Respite services rendered in the member's own private residence may also be billed at an hourly fixed rate which does not include room and board related expenses.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- ☐ **No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ☒ **Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the**

waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

- ☒ **No. The state does not impose a co-payment or similar charge upon participants for waiver services.**
- ☐ **Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)**

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

- ☒ No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- ☐ Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	5256.10	23311.81	28567.91	66152.88	12815.56	78968.44	50400.53
2	6328.16	24570.65	30898.81	69725.14	13507.60	83232.74	52333.93
3	5083.87	20637.06	25720.93	73490.29	14237.01	87727.30	62006.37
4	6095.49	21276.81	27372.30	77458.77	15005.81	92464.58	65092.28
5	2159.74	25299.98	27459.72	78403.23	10116.17	88519.40	61059.68

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (1 of 9)**

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	638		638
Year 2	1108		1108
Year 3	1204		1204
Year 4	1400		1400
Year 5	1600		1600

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay for years 1 through 2 is based on Form 372 for FY20.

The average length of stay for years 3 through 4 is based on Form 372 for FY22.

The average length of stay for year 5 is based on Form 372 for FY24.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

The number of users from the FY20 372 report was used to estimate the number of users for waiver years 1 and increased annually by 9.6% for WY 1 - 5 except for the service for which there is no FY20 372 data. Forty-eight percent is the approximate increase in the unduplicated count projection from WY 3 (FY20) of the most current amendment to WY 1 of the renewal, 48% divided by 5 waiver years is 9.6%.

The number of users for the Respite Daily services for WY 1 is based on prorated projections for waiver year 2 for the Community Waiver, and increased annually by 9.6% for WY 1 - 5, based on the approximate 48% increase in the unduplicated count from WY 3 (FY20) of the most current amendment to WY 1 of the renewal. Forty-eight percent averaged over 5 waiver years is 9.6%.

Average units per user for waiver years 1-5 are based on utilization identified on Form 372 for FY20 except for the service for which there is no data. The state does not expect the number of units per user to deviate significantly from FY20 372 data based on the consistency in the number of units from FY19 to FY20 372 data.

Average number of units per users for Respite Daily service for WY 1-5 is based on prorated projections for WY 2 for the Community Waiver.

The Factor D estimate for costs per unit for WY 1 was based on FY20 372 data and increased annually by 5.4% for WY 1-5 except for the services for which there is no FY20 372 data (Respite Daily service). A 5.4% annual increase was applied to Factor D rate estimates for WY 1-5. The 5.4% annual increase was based on the average Consumer Price Index (CPI) from the Bureau of Labor Statistics for October 2021.

The estimate for costs per unit for Respite Daily service for WY 1 is based on prorated projections for waiver year 2 for the Community Waiver. A 5.4% annual increase was applied to cost per unit estimates for Respite Daily services for WY 1-5. The 5.4% annual increase was based on the average Consumer Price Index (CPI) from the Bureau of Labor Statistics for October 2021.

A Provider rate increase of 25% was applied to most rates as approved by the state for WY 1-5. Appendix J estimates for WY1 include only 75% of the annual rate increase amount since the requested effective date is October 1, 2022.

In each waiver year W1-W5, the number of users for each service is increased by the approximate percentage increase in the unduplicated count for each waiver year.

The approximate increase in the unduplicated count for WY1 is 155%. The number of users for each service is increased by 155% in WY1. The approximate increase in the unduplicated count for WY2 is 343%. The number of users for each service is increased by 343% in WY2. The approximate increase in the unduplicated count for WY3 is 382%. The number of users for each service is increased by 382% in WY3. The approximate increase in the unduplicated count for WY4 is 460%. The number of users for each service is increased by 460% in WY4. The approximate increase in the unduplicated count for WY5 is 540%. The number of users for each service is increased by 540% in WY5.

The following updates were made to WY 3-5 based on the FY22 372 reports:

The number of users for the Self-Directed Habilitation Training Specialist service was reduced.

The number of users and the average units per user for the Habilitation Training Specialist service were reduced.

The number of users for the Prevocational service was reduced.

The number of users and the average units per user for the Respite service were reduced.

The number of users and the average units per user for the Supported Employment (Individual) service were reduced.

The number of users and the average units per user for the Supported Employment (Group) service were reduced.

The number of users for the Environmental Accessibility Adaptations/Architectural Modifications service was reduced.

The average number of units per user for the Family Training (Individual Training) service was increased.

The average number of units per user for the Family Training (Group Training) service was increased.

The number of users for the Occupational/Physical Therapy service was decreased.

The average number of units per user for Self-Directed Goods & Services was decreased.

The number of users and the average units per user for the Specialized Medical Supplies service were reduced.

The average number of units per user for the Assistive Technology service was increased.

A Provider rate increase was applied to the following services as approved by the state for WY 3-5:

A Provider rate increase of 25% was applied to Habilitation Training Specialist Services and Self-Directed Habilitation Training Specialist Services as approved by the state for WY 3-5.

A Provider rate increase of 10% rate increase was applied to Prevocational, Respite, Supported Employment - Individual, Supported Employment - Group, Respite Daily - In Home, and Respite Daily - Out of Home services as approved by the state for WY 3-5.

Appendix J estimates for WY3 include only 75% of the annual rate increase amount since the requested effective date is October 1, 2024.

Factor D estimates for the number of users for W5 are based on the FY24 372 reports.

The number of users for these services was increased based on the FY24 372 reports: Respite, Occupational and Physical Therapy, and Family Training (Individual Training).

The number of users for these services was decreased based on the FY24 372 reports: Habilitation Training Specialist (Self-Direction), Habilitation Training Specialist, Environmental Accessibility Adaptations and Architectural Modifications, Family Training (Group Training), Respite Daily (Out of Home), Self-Directed Goods and services, Assistive Technology, and Specialized Medical Supplies.

Average units per user for WY5 were based on the utilization identified in Form 372 for FY24.

The number of units per user for this service was increased based on the FY24 372 reports: Habilitation Training Specialist, Family Training (Individual Training), and Specialized Medical Supplies.

The number of units per user for these services was decreased based on the FY24 372 reports: Self-Directed Goods and Services, Habilitation Training Specialist (Self-Direction), Respite, Family Training (Group Training), Occupational and Physical Therapy, Respite Daily (In-Home and Out of Home), Assistive Technology, and Specialized Medical Supplies.

The rates for the following services are based on the FY24 372 report, then trended forward by 2.6% through WY5: Environmental Accessibility Adaptations and Architectural Modifications, Self-Directed Goods and Services, Specialized Medical Supplies, and Assistive Technology. The 2.6% annual increase was based on the Consumer Price Index (CPI) from the Bureau of Labor Statistics for August 2025.

The average rates per unit were increased for Self-Directed Goods and Services and Assistive Technology.

The average rates per unit were decreased for Environmental Accessibility Adaptations and Architectural Modifications and Specialized Medical Supplies.

The average rates per unit for the other services in this waiver were updated based on current approved rates.

The rates for the following services were increased based on current rates: Family Training (Group Training), and Occupational and Physical Therapy.

The rates for the following services were decreased based on current rates: Habilitation Training Specialist (Self-Direction), Habilitation Training Specialist, Respite, Family Training (Individual Training), and Respite Daily (In-Home and Out of Home).

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' from the FY20 372 report is increased annually by 5.4% for WY 4 - 5 of the current waiver. WY 1 of the renewal is based on this WY 5 estimate and trended forward by 5.4%. WY 2 - 5 of the renewal are also increased annually by 5.4%. The 5.4% annual increase was based on the Consumer Price Index (CPI) from the Bureau of Labor Statistics for October 2021.

Factor D' from the FY22 372 report is trended forward by an annual increase of 3.1% for WY 3-5 of the current waiver. The 3.1% annual increase was based on the Consumer Price Index (CPI) from the Bureau of Labor Statistics for November 2023.

Factor D' is based on the FY24 372 report data. Factor D' from the FY24 372 report is trended forward annually by 2.6% from FY24 through WY5 of the current waiver. The 2.6% annual increase was based on the average Consumer Price Index (CPI) from the Bureau of Labor Statistics for August 2025.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is based on the FY20 Oklahoma ICF/IID costs. The average annual cost for ICF/IID care in FY20 was increased annually by 5.4% for WY 4 - 5 of the current waiver. WY 1 of the renewal is based on this WY 5 estimate and trended forward by 5.4%. WY 2 - 5 of the renewal are also increased annually by 5.4%. The 5.4% annual increase was based on the average Consumer Price Index (CPI) from the Bureau of Labor Statistics for October 2021.

Factor G for WY5 is based on the FY26 Oklahoma ICF/IID annual costs of \$76,416.40. The average annual cost for ICF/IID care in FY26 (WY4) of \$76,416.40 is trended forward by 2.6% through WY5 ($\$76,416.40 \times 1.026 = \$78,403.23$). The 2.6% annual increase is based on the Consumer Price Index (CPI) from the Bureau of Labor Statistics for August 2025.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is based on a query of FY20 Medicaid acute care institutional costs. The state reran the cost report for acute care services received by institutionalized recipients for FY20 to confirm Factor G'. The average cost per person was \$10,945. Factor G' from the FY20 cost report is increased annually by 5.4% for WY 4 - 5 of the current waiver. WY 1 of the renewal is based on this WY 5 estimate and trended forward by 5.4%. WY 2 - 5 of the renewal are also increased annually by 5.4%. The 5.4% annual increase was based on the average Consumer Price Index (CPI) from the Bureau of Labor Statistics for October 2021.

Factor G' is based on a query of FY24 Medicaid acute care institutional costs. Factor G' from the FY24 cost report of \$9366.43 is trended forward annually by 2.6% from FY24 (WY2) through WY5. Calculations are as follows: FY24 costs = \$9366.43. $\$9,366.43 \times 1.026 = \$9,609.96$ for FY25. $\$9,609.96 \times 1.026 = \$9,859.82$ for FY26. $\$9,859.82 \times 1.026 = \$10,116.17$. The 2.6% annual increase was based on the average Consumer Price Index (CPI) from the Bureau of Labor Statistics for August 2025.

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Habilitation Training Specialist Services	
Prevocational Services	
Respite	
Supported Employment	
Environmental Accessibility Adaptations and Architectural Modification	
Family Training	
Occupational and Physical Therapy	
Respite Daily	
Self Directed Goods and Services (SD-GS)	
Specialized Medical Supplies and Assistive Technology	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Training Specialist Services Total:						2754940.00
Self Directed	1 hour	89	322.00	20.00	573160.00	
Habilitation Training Specialist Services	1 hour	207	527.00	20.00	2181780.00	
Prevocational Services Total:						6000.00
Prevocational Services	1 hour	3	100.00	20.00	6000.00	
Respite Total:						22040.00
Respite - Hourly	1 hour	8	145.00	19.00	22040.00	
Supported Employment Total:						46068.00
Individual	1 hour	3	400.00	21.95	26340.00	
GRAND TOTAL: 3353394.84 Total Estimated Unduplicated Participants: 638 Factor D (Divide total by number of participants): 5256.10 Average Length of Stay on the Waiver: 291						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group	1 hour	3	400.00	16.44	19728.00	
Environmental Accessibility Adaptations and Architectural Modification Total:						35912.40
Environmental Accessibility Adaptations and Architectural Modification	Per Item	10	1.00	3591.24	35912.40	
Family Training Total:						66567.60
Group Training	Session	46	20.00	54.45	50094.00	
Individual Training	Session	18	8.00	114.40	16473.60	
Occupational and Physical Therapy Total:						889.20
Occupational and Physical Therapy	15 min,	3	12.00	24.70	889.20	
Respite Daily Total:						244806.24
In Home	Per Item	28	18.00	116.04	58484.16	
Out of Home	Per Item	46	28.00	144.66	186322.08	
Self Directed Goods and Services (SD-GS) Total:						113863.20
Self Directed Goods and Services (SD-GS)	Per Item	66	38.00	45.40	113863.20	
Specialized Medical Supplies and Assistive Technology Total:						62308.20
Assistive Technology	Per Item	56	7.00	84.60	33163.20	
Specialized Medical Supplies	Per Item	87	335.00	1.00	29145.00	
GRAND TOTAL: 3353394.84 Total Estimated Unduplicated Participants: 638 Factor D (Divide total by number of participants): 5256.10 Average Length of Stay on the Waiver: 291						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Training Specialist Services Total:						5807877.46
Self Directed	1 hour	168	322.00	22.19	1200390.24	
Habilitation Training Specialist Services	1 hour	394	527.00	22.19	4607487.22	
Prevocational Services Total:						8876.00
Prevocational Services	1 hour	4	100.00	22.19	8876.00	
Respite Total:						55018.80
Respite - Hourly	1 hour.	18	145.00	21.08	55018.80	
Supported Employment Total:						68144.00
Individual	1 hour	4	400.00	24.35	38960.00	
Group	1 hour	4	400.00	18.24	29184.00	
Environmental Accessibility Adaptations and Architectural Modification Total:						83273.74
Environmental Accessibility Adaptations and Architectural Modification	Per Item	22	1.00	3785.17	83273.74	
Family Training Total:						130177.60
Group Training	Session	84	20.00	57.39	96415.20	
Individual Training	Session	35	8.00	120.58	33762.40	
Occupational and Physical Therapy Total:						1315.20
Occupational and Physical Therapy	15 min.	4	12.00	27.40	1315.20	
Respite Daily Total:						500323.50
In Home	Per Item	53	18.00	128.75	122827.50	
Out of Home	Per Item	84	28.00	160.50	377496.00	
Self Directed Goods and Services (SD-GS) Total:						232742.40
Self Directed Goods and Services (SD-GS)	Per Item	128	38.00	47.85	232742.40	
Specialized Medical Supplies and Assistive						123851.14
GRAND TOTAL: 7011599.84 Total Estimated Unduplicated Participants: 1108 Factor D (Divide total by number of participants): 6328.16 Average Length of Stay on the Waiver: 291						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Technology Total:						
Assistive Technology	Per Item	106	7.00	89.17	66164.14	
Specialized Medical Supplies	Per Item	164	335.00	1.05	57687.00	
GRAND TOTAL: 7011599.84 Total Estimated Unduplicated Participants: 1108 Factor D (Divide total by number of participants): 6328.16 Average Length of Stay on the Waiver: 291						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Training Specialist Services Total:						4149776.40
Self Directed	1 hour	110	322.00	27.78	983967.60	
Habilitation Training Specialist Services	1 hour	385	296.00	27.78	3165808.80	
Prevocational Services Total:						5028.00
Prevocational Services	1 hour	2	100.00	25.14	5028.00	
Respite Total:						8596.80
Respite - Hourly	1 hour	4	90.00	23.88	8596.80	
Supported Employment Total:						19300.00
Individual	1 hour	4	100.00	27.58	11032.00	
Group	1 hour	4	100.00	20.67	8268.00	
Environmental Accessibility Adaptations and Architectural Modification Total:						39895.70
Environmental					39895.70	
GRAND TOTAL: 6120982.24 Total Estimated Unduplicated Participants: 1204 Factor D (Divide total by number of participants): 5083.87 Average Length of Stay on the Waiver: 296						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Accessibility Adaptations and Architectural Modification	Per Item	10	1.00	3989.57		
Family Training Total:						578775.60
Group Training	Session	101	84.00	60.49	513197.16	
Individual Training	Session	43	12.00	127.09	65578.44	
Occupational and Physical Therapy Total:						1039.68
Occupational and Physical Therapy	15 min.	3	12.00	28.88	1039.68	
Respite Daily Total:						679699.72
In Home	Per Item	63	18.00	145.88	165427.92	
Out of Home	Per Item	101	28.00	181.85	514271.80	
Self Directed Goods and Services (SD-GS) Total:						132025.74
Self Directed Goods and Services (SD-GS)	Per item	154	17.00	50.43	132025.74	
Specialized Medical Supplies and Assistive Technology Total:						506844.60
Assistive Technology	Per Item	125	43.00	93.99	505196.25	
Specialized Medical Supplies	Per Item	5	297.00	1.11	1648.35	
GRAND TOTAL: 6120982.24 Total Estimated Unduplicated Participants: 1204 Factor D (Divide total by number of participants): 5083.87 Average Length of Stay on the Waiver: 296						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Training Specialist Services Total:						5875836.72
Self Directed	1 hour	140	322.00	30.81	1388914.80	
Habilitation Training Specialist Services	1 hour	492	296.00	30.81	4486921.92	
Prevocational Services Total:						5424.00
Prevocational Services	1 hour	2	100.00	27.12	5424.00	
Respite Total:						9270.00
Respite - Hourly	1 hour	4	90.00	25.75	9270.00	
Supported Employment Total:						20820.00
Individual	1 hour	4	100.00	29.76	11904.00	
Group	1 hour	4	100.00	22.29	8916.00	
Environmental Accessibility Adaptations and Architectural Modification Total:						42050.10
Environmental Accessibility Adaptations and Architectural Modification	Per Item	10	1.00	4205.01	42050.10	
Family Training Total:						780917.76
Group Training	Session	129	84.00	63.76	690903.36	
Individual Training	Session	56	12.00	133.95	90014.40	
Occupational and Physical Therapy Total:						1095.84
Occupational and Physical Therapy	15 min.	3	12.00	30.44	1095.84	
Respite Daily Total:						929312.88
In Home	Per Item	78	18.00	157.33	220891.32	
Out of Home	Per Item	129	28.00	196.13	708421.56	
Self Directed Goods and Services (SD-GS) Total:						177095.80
Self Directed Goods and Services (SD-GS)	Per item	196	17.00	53.15	177095.80	
Specialized Medical Supplies and Assistive						691859.07
GRAND TOTAL: 8533682.17 Total Estimated Unduplicated Participants: 1400 Factor D (Divide total by number of participants): 6095.49 Average Length of Stay on the Waiver: 296						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Technology Total:						
Assistive Technology	Per Item	162	43.00	99.07	690121.62	
Specialized Medical Supplies	Per Item	5	297.00	1.17	1737.45	
GRAND TOTAL: 8533682.17 Total Estimated Unduplicated Participants: 1400 Factor D (Divide total by number of participants): 6095.49 Average Length of Stay on the Waiver: 296						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Habilitation Training Specialist Services Total:						3032432.44
Self Directed	1 hour	135	309.00	19.16	799259.40	
Habilitation Training Specialist Services	1 hour	161	527.00	26.32	2233173.04	
Prevocational Services Total:						5716.00
Prevocational Services	1 hour	2	100.00	28.58	5716.00	
Respite Total:						10956.00
Respite - Hourly	1 hour	6	83.00	22.00	10956.00	
Supported Employment Total:						21944.00
Individual	1 hour	4	100.00	31.36	12544.00	
Group	1 hour	4	100.00	23.50	9400.00	
Environmental Accessibility Adaptations and Architectural Modification Total:						11779.44
Environmental					11779.44	
GRAND TOTAL: 3455591.24 Total Estimated Unduplicated Participants: 1600 Factor D (Divide total by number of participants): 2159.74 Average Length of Stay on the Waiver: 294						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Accessibility Adaptations and Architectural Modification	Per Item	6	1.00	1963.24		
Family Training Total:						123486.55
Group Training	Session	24	4.00	330.50	31728.00	
Individual Training	Session	65	13.00	108.59	91758.55	
Occupational and Physical Therapy Total:						6659.01
Occupational and Physical Therapy	15 min.	27	1.00	246.63	6659.01	
Respite Daily Total:						16786.00
In Home	Per Item	10	18.00	71.30	12834.00	
Out of Home	Per Item	4	10.00	98.80	3952.00	
Self Directed Goods and Services (SD-GS) Total:						84877.10
Self Directed Goods and Services (SD-GS)	Per item	154	5.00	110.23	84877.10	
Specialized Medical Supplies and Assistive Technology Total:						140954.70
Assistive Technology	Per Item	30	6.00	772.26	139006.80	
Specialized Medical Supplies	Per Item	3	755.00	0.86	1947.90	
GRAND TOTAL: 3455591.24 Total Estimated Unduplicated Participants: 1600 Factor D (Divide total by number of participants): 2159.74 Average Length of Stay on the Waiver: 294						