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 §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 waivers 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:
Homeward Bound Waiver

C. Waiver Number:OK.0399
Original Base Waiver Number: OK.0399.90

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/22
Approved Effective Date of Waiver being Amended: 07/01/21

2. Purpose(s) of Amendment

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

Appendix A - The Medicaid Agency Oversight of Operating Agency Performance section has been updated to reflect current practice related to sharing of information between OKDHS and OHCA.

Appendix C - Due to a statutory language change (Title 56 OS Sec. 1025.1 et seq.: OAC 340:100-3-39), the scope of background investigation language has been updated to include the option of a Federal Bureau of Investigation (FBI) Identity History Summary Check.

Appendix C - The limits section of the Transportation service has been updated to reflect an increased limit for public transportation. The limit has been increased from $5000.00 to $25,000.00, per 12 months.

Appendix C - The Dental Service Type was updated from Other Service to Extended State Plan Service.

Appendix C - The Optometry service has been added to the Participant Services section.

Appendix C - Oklahoma currently offers a retainer payment for some services. This payment, which is referred to as therapeutic leave, allows service providers to retain personal care services during the time a member is out of his or home for a period of time in excess of 24 hours without direct care staff because of hospitalization or other absence. The therapeutic leave payment has been added to the Specialized Foster Care service.

Appendix C - The Supported Employment service has been updated to include a statement indicating the service may be provided remotely, with prior approval by the Team.

Appendix C - The Environmental Accessibility Adaptations and Architectural Modification service limit section has been updated to allow a designee, as well as the DHS/DDS Division Administrator, to authorize modification of more than two different residences in a seven year period, in extenuating circumstances.

Appendix C - Medicaid certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) has been removed as a provider of the Respite Daily service.

Appendix C - The limits section of the Family Training service has been updated to increase the individual limit from $5500.00 per plan of care year to $6500.00 per plan of care year. The group limit has also been increased from $5500.00 per plan of care year to $6500.00 per plan of care year. The total for Family Training services may not exceed $13,000.00 per plan of care year.

Appendix C - The Occupational Therapy service definition has been updated to require a prescription by any licensed health care provider, not just a Physician, with appropriate prescriptive authority.

Appendix C - The Physical Therapy service definition has been updated to require a prescription by any licensed health care provider, not just a Physician, with appropriate prescriptive authority.

Appendix C - A statement indicating the Prevocational service may be provided remotely, with prior approval by the Team, has been added to the Prevocational service definition.

Appendix C - A statement indicating the Daily Living Supports service may be provided remotely, with prior approval by the Team, has been added to the Daily Living Supports service definition.

Appendix D - The Service Plan Development section has been updated to allow Team meetings, including Individual Plan meetings, to be conducted via HIPAA compliant teleconference or video conference.

Appendix I - Specialized Medical Supplies and Assistive Technology service, Rate Determination Method language has been updated.

Appendix I - The Optometry service has been added as a Medicaid rate to the Rate Determination Method section.

Appendix J - Due to the addition of the Optometry service, the Public Transportation limit increase and the Remote Supports service rate increase, cost neutrality estimates have been adjusted.

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**	Main 6.I.
☒ **Appendix A Waiver Administration and Operation**	2:b
☐ **Appendix B Participant Access and Eligibility**	
☒ **Appendix C Participant Services**	2:a and e
☒ **Appendix D Participant Centered Service Planning and Delivery**	1:c
☐ **Appendix E Participant Direction of Services**	
☐ **Appendix F Participant Rights**	
☐ **Appendix G Participant Safeguards**	
☐ **Appendix H**	
☒ **Appendix I Financial Accountability**	2:a
☒ **Appendix J Cost-Neutrality Demonstration**	

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:

Public Input section updated.
Scope of background investigation update to include the Federal Bureau of Investigation (FBI) Identity History Summary Check.
Rate Determination Method section updated to include the new Optometry service.
Specialized Medical Supplies and Assistive Technology service pricing methodology updated in the Rate Determination Method section.
Service Plan Development section updated to allow Team meetings, including Individual Plan meetings, to be conducted via HIPAA compliant teleconference or video conference.

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 §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*):

Homeward Bound Waiver

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.0399
Draft ID: OK.006.04.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/21
Approved Effective Date of Waiver being Amended: 07/01/21

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and 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: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 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 in42 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 §1915(a)(1)(a) of the Act and described in Appendix I**

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

☐ **A program operated under §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 §1915(i) of the Act.**

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

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity 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 Homeward Bound Waiver is intended to better meet the home and community based services needs of members representing the Plaintiff Class in Homeward Bound et al v. The Hissom Memorial Center et al, United States District Court, Northern District of Oklahoma, Case No. 85-C-437-e. The purpose of the Homeward Bound Waiver is to assist class members 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 Homeward Bound Waiver is a service system centered on the needs and preferences of the class members and supports the integration of participants within their communities. Services provide residential and comprehensive supports for class members. The Homeward Bound waiver is a self-determined waiver. The number of participants served will decrease as class members leave the waiver.

The Developmental Disabilities Services (DDS) of the Oklahoma Department of Human Services (DHS), through an Interagency Agreement with the state's Medicaid agency, the Oklahoma Health Care Authority (OHCA), operates the Homeward Bound Waiver for members of the plaintiff class with an intellectual disability or related condition. This waiver provides services and payment for those services that are not otherwise covered through Oklahomas Medicaid program (hereinafter referred to as SoonerCare). Homeward Bound waiver 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 persons who otherwise would not be able to live in a home and community-based setting. The waiver is operated on a statewide basis. Employees of DHS provide case management services. Case Managers are located in offices throughout the state. Case Managers assure that individual needs are assessed and identified and coordinate the Personal Support Team (Team) for each individual class member.

The services and supports provided are identified by the class members Team during the meeting to develop the member's Individual Plan (Plan). A DHS/DDS Case Manager develops a plan of care in accordance with Oklahoma Administrative Code (OAC) 340:100-5-53. The Plan contains detailed descriptions of services provided, documentation of amount, frequency and duration of services as well as the types of service providers. Services are authorized based on service authorization policy, OAC 340:100-3-33 and 3-33.1. Services are provided by qualified agencies or individuals who have entered into an Agreement with OHCA. The Case Manager assists the class member to select qualified providers of his or her choice. The Case Manager also coordinates and monitors the provision of these services in accordance with the member's Plan and makes necessary changes to assure the health and welfare of the class member. In addition, the Quality Assurance Unit of DHS/DDS monitors quality of services provided and contracts with outside organizations to monitor satisfaction of members 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.

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.

Telehealth may be utilized to deliver Speech Therapy, Physical Therapy, Occupational Therapy, Audiology, Psychology, Nutrition, Family Training, Family Counseling, Nursing and Dental 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. 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.

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 §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 §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. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness 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 §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 in-patients 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 §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §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. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, 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 §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 opportunity for public input to the waiver amendment process:

In order to fulfill the non-electronic requirements for public comment, the State posted written notices in all county offices to ensure meaningful opportunities for input for individuals served or eligible to be served in the waiver. The public notice contained a summary of the changes and instruction where individuals could submit comments and request a full copy of the waiver. This comment period was open from January 18, 2022 through February 18, 2022.

The Homeward Bound waiver amendment was placed on the OHCA website for public comment from January 18, 2022 through February 18, 2022.

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) 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:

DDS Medicaid Services Director

Agency:

Oklahoma Department of Human Services

Address:

P.O. Box 25352

Address 2:

2400 N. Lincoln Blvd.

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 §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:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Oklahoma**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

Attachments

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:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State assures that this waiver amendment will be subject to any provisions or requirements included in the State's most recent and/or approved home and community-based settings Statewide Transition Plan. The State will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

I-2:a. Rate Determination Method (continued)

Therapy Services:

The rate setting methodology for therapy services were reviewed in September 2012. At that time DDS therapy service rates had not been increased since 1997. Per the rate brief, the average Consumer Price Index (CPU) had increased at an annual rate of 2.2% since 2006 and the price of gasoline, which is a major cost center for these services, has increased at an annual rate of 4.8% since 2006. SB1979 authorized $1.5 million in appropriated funds for “an increase in reimbursement rates for the DDS programs in FY13. The proposed rate increases honor this legislative intent. Therapy rates for occupational and physical were increased from $13.75 to $20.00, for a total of a $6.25 increase which equates to 45.5%. Therapy rates for speech were increased to $18.79 in 2005. In addition, OHCA agreed to maintain parity between the waiver service programs in their core in home services. The rates were determined by utilization of services, the last time a rate increase was done for those services, and a comparison of rates in other states. Due to a 4% rate increase mandated by the Oklahoma Legislature in 2019, Occupational Therapy and Physical Therapy services increased to $20.80 per 15 minute unit increment and the Speech Therapy service rate increased to $19.54 per 15 minute unit increment. Oklahoma Legislature will mandate any future change in therapy service rates.

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.

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.

Rates were rebased in 2015. The factors and methodology used for determining rates are based on the market rate of providers and individuals employed within the industry. The term market rate is defined as the agreed upon pricing point, in an open market, between a provider of service or labor and the vendor or employee. The agreed upon price is evidenced by actual contracts or employment at the pricing point.

Data compiled by the Oklahoma Employment Security Commission serves as a baseline for labor rates within the industry and similar industries competing for the same targeted employee. The base labor rate within an industry has causal effect on the skills, education and experience of labor. Oklahoma seeks to serve our citizens with the most highly qualified service providers and recognizes this starts with the employee.

The second component assessed is the service provider. As fixed labor costs increase, so do variable costs. The administrative or management component must reflect the changing cost of labor to insure an adequate supply of services for the individuals served. A key concept in the rate setting philosophy is that although services are heavily subsidized in a limited market, the individuals providing the services are recruited from a very competitive labor market. Finally, we monitor labor rates as a

component of the rate to assess the impact of rate changes to direct labor rates.

Utilizing Appendix K, effective March 1, 2020, CMS approved the addition of the telehealth service delivery option for the following services: Speech Therapy, Physical Therapy, Occupational Therapy, Audiology, Psychology, Nutrition, Family Training, Family Counseling, Nursing and Dental. Effective July 1, 2021, the telehealth service delivery option was added to this waiver for these services. The addition of telehealth as a delivery option does not impact rates or rate methodology.

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 Division (DDSD)

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. In addition, a SoonerCare Fast Facts on Home and Community-Based Services Waivers is published quarterly along with OHCA's Long Term Care Administration monthly Fast Facts. These documents are presented by the State Medicaid Director in monthly meetings of the OHCA Board.

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 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. When a significant change affecting the members qualifying diagnosis is suspected, Case Managers gather necessary documentation and submit to OHCA LOCEU to determine level of care.

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 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 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.

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.:*

- ◉ **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:

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:

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.*

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment	☒	☒
Waiver enrollment managed against approved limits	☒	☒
Waiver expenditures managed against approved levels	☒	☒
Level of care evaluation	☒	☒

Function	Medicaid Agency	Other State Operating Agency
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 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 States quality improvement strategy, provide information in the following fields to detail the States 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 approved and reviewed by OHCA (denominator) for which OKDHS/DDS verified provider information prior to verification by OHCA and initiation of provider Agreement (numerator).

Data Source (Select one):
Other
If 'Other' is selected, specify:
OKDHS/DDSD 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**

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 policy pertaining to DHS/DDS waiver members submitted to (denominator) and approved by OHCA (numerator).

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 (denominator) furnished within 45 working days of the close of the quarter to the State Medicaid Director and Waiver Administration Unit (numerator).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report prepared by DHS/DDS

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 prior authorizations(denominator) submitted to and reviewed by OHCA that are within approved levels (numerator).

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**

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 monthly enrollment reports (denominator) submitted to and reviewed by OHCA that are within approved levels (numerator).

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 provider Agreement applications for licensed providers approved and reviewed by OHCA (denominator) for which DHS/DDS verified appropriate licensure/certificate in accordance with the State law and waiver provider qualifications prior to verification by OHCA and initiation of provider Agreement (numerator).

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 (denominator) and approved for DHS/DDS by the OHCA Board of Directors (numerator).

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**

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 required provider performance monitoring reviews (denominator) conducted by DHS/DDS and reported to and reviewed by OHCA (numerator).

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:

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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. 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** 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 SubGroup	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**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☒	Intellectual Disability	21		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Homeward Bound is further limited to individuals over the age of 21 who have been certified by the United States District Court for the Northern District of Oklahoma as a member of the Plaintiff Class in Homeward Bound et al., Case No. 85-C-437-e.

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:

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 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)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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:

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:

☐ **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	640
Year 2	640
Year 3	640
Year 4	640
Year 5	640

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).**

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:

Individuals who are certified as members of the Plaintiff Class in Homeward Bound et al. v. The Hissom Memorial Center may enter the waiver at any time as long as all other factors of eligibility are met.

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)*:

- ○ **§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)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☒ **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 §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §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 §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 §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, 2019 (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 §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 §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §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 periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §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 §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 (SSI 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 §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 periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

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 §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 periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

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 periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §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 §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:

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 five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §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: 1

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 a government agency under contract with the Medicaid agency.**

Specify the entity:

- ◉ **Other**

Specify:

The OHCA Level of Care Evaluation Unit performs initial evaluations and reevaluations where there appears to be a significant change which questions the 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:

A person must be a Qualified Intellectual Disability Professional (QIDP) to perform initial evaluations of level of care for waiver applicants. To qualify as a QIDP a person must have a Baccalaureate Degree in a social science, behavioral science or human services field and have at least one year of experience working directly with persons with a developmental or intellectual disability.

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 defined in the Diagnostic and Statistical Manual of Mental Disorders; 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 social service summary current within 12 months of requested waiver approval date that includes a developmental history; a medical evaluation current within one year of requested waiver approval date; a completed ICF-IID Level of Care Assessment form; and proof of disability according to Social Security Administration (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 the reevaluation as the initial evaluation except the DHS/DDS Level of Care Reviewer is responsible for conducting routine reevaluations. 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 be a Qualified Intellectual Disability Professional (QIDP) to perform initial evaluations of level of care for waiver applicants. To qualify as a QIDP a person must have a Baccalaureate Degree in a social science, behavioral science or human services field and have at least one year of experience working directly with persons with intellectual disability or other developmental disability.

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 a human services field and one year of experience working directly with individuals with developmental or intellectual disabilities; or possession of a valid permanent Oklahoma license as approved by the Oklahoma Board of Nursing to practice professional nursing and one year working directly with individuals with developmental or intellectual disabilities.

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 and a copy is maintained electronically in the DDS case management database.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
Number and percent of applicants for whom there is reasonable indication that services may be needed in the future(denominator) who had a level of care determination(numerator).

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:

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 (denominator) that are accurately completed by a QIDP prior to receipt of services(numerator).

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:
Number and percent of member's initial level of care evaluations (denominator) where the processes and instruments were applied appropriately as described in the approved waiver prior to receipt of services (numerator).

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(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 initial level of care evaluations (denominator)where level of care criteria was accurately applied prior to receipt of services(numerator).

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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The operating agency follows up on each identified problem to ensure it 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*(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 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 DHS/DDS determines an individual may require ICF/IID level of care, the individual or his 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 a Home and Community-Based Services (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 waiver services and outlines the freedom to choose from any available provider of HCBS waiver services. DHS/DDS Intake staff inform potential members of the services available through the waiver and routinely provides this information verbally and by providing informational pamphlets to potential waiver members and their legal representatives. The 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 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	**Adult Day Health**
Statutory Service	**Habilitation Training Specialist Services**
Statutory Service	**Homemaker**
Statutory Service	**Prevocational Services**
Statutory Service	**Respite**
Statutory Service	**Supported Employment**
Extended State Plan Service	**Dental Services**
Extended State Plan Service	**Nursing**
Extended State Plan Service	**Prescribed Drugs**
Other Service	**Agency Companion Services**
Other Service	**Audiology Services**
Other Service	**Daily Living Supports**
Other Service	**Environmental Accessibility Adaptations and Architectural Modification**
Other Service	**Extended Duty Nursing**

Service Type	Service
Other Service	Family Counseling
Other Service	Family Training
Other Service	Group Home Services
Other Service	Intensive Personal Supports
Other Service	Nutrition Services
Other Service	Occupational Therapy Services
Other Service	Optometry
Other Service	Physical Therapy Services
Other Service	Physician Services (provided by a Psychiatrist)
Other Service	Psychological Services
Other Service	Remote Supports
Other Service	Respite Daily
Other Service	Specialized Foster Care also known as Specialized Family Home/Care
Other Service	Specialized Medical Supplies and Assistive Technology
Other Service	Speech Therapy Services
Other Service	Transportation

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:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04060 adult day services (social model)

Category 2:

04 Day Services

Sub-Category 2:

04050 adult day health

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

This service provides assistance with the retention or improvement of self-help, adaptive and socialization skills including the opportunity to interact with peers in order to promote maximum level of independence and functioning. Services are provided in a non-residential setting separate from the home or facility where the member resides. This 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:

Services are furnished a minimum of four or more hours per day on a regularly scheduled basis, for a minimum of one or more days per week.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Adult Day Care Centers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Care Centers

Provider Qualifications

License *(specify):*

Licensed by the State Department of Health in accordance with Section 1-873 of Title 63 of the Oklahoma Statutes and compliance with Oklahoma Administrative Code 310:605-5.

Certificate *(specify):*

Other Standard *(specify):*

Current SoonerCare Provider Agreement with the Oklahoma Health Care Authority to provide Adult Day Care Services to DHS/DDS HCBS waiver members.

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma State Department of Health
Oklahoma Health Care Authority

Frequency of Verification:

Oklahoma State Department of Health - Annually
Oklahoma Health Care Authority - Ongoing

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:

Habilitation

Alternate Service Title (if any):

Habilitation Training Specialist Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08010 home-based habilitation
Category 3:	**Sub-Category 3:**
08 Home-Based Services	08030 personal care
Category 4:	**Sub-Category 4:**
04 Day Services	04070 community integration

Service Definition *(Scope):*

This includes services to support a 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 familys residence.

Habilitation Training Specialist (HTS) services are authorized in an acute care hospital 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.

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

The DDS director or designee may authorize HTS services provided in psychiatric facilities when required for admission to address issues such as significant daily living, communication and other needs.

HTS services in an acute care hospital are not provided at the same time as Daily Living Supports therapeutic leave, per OAC 317:40-5-150 or 317:40-5-153.

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

Payment will not be made for routine care and supervision that is normally provided by family or for services furnished to a member by a person who is legally responsible per Oklahoma Administrative Code 340:100-3-33-2.

Habilitation Training Specialist (HTS) services are available in an acute care hospital for no more than 14 consecutive, calendar days per event, not to exceed 60-calendar days per Plan of Care year. This service is limited to 24 hours per day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Habilitation Training Specialist Agency
Individual	Individual Provider

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 HTS services 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.

Family members who provide Habilitation Training Specialist (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:

Individual

Provider Type:

Individual Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Current SoonerCare Provider Agreement with OHCA to provide HTS services 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.

Family members who provide Habilitation Training Specialist (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:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

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

Services consisting of general household activities such as meal preparation and routine household care provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Agency Homemaker providers are supervised by provider 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. Individual Homemaker providers are supervised by DHS/DDS residential program staff.

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**

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	Individual Homemaker
Agency	Homemaker Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Individual Homemaker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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: Homemaker

Provider Category:

Agency

Provider Type:

Homemaker Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Providers must complete the DHS/DDS sanctioned training curriculum. Homemaker 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).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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.

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:

Refer to Appendix C-4: Additional Limits on Amounts of Waiver Services

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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 approved 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 approved 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:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**

09 Caregiver Support | 09011 respite, out-of-home

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

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

Services 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 care is provided in the following locations: member's home or place of residence or approved community site, Agency Companion home or Specialized Foster Care home.

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

Payment is not made for daily respite care and Specialized Foster Care or Agency Companion services for the same member on the same date of service.

Respite care:

- is not available to members in the custody of 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 DHS/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**

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: 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:

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, 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:

Annually

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:

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:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**
03 Supported Employment	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. With prior approval by the Team, this service may be provided remotely. 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 five 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.).

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

Refer to Appendix C-4: Additional Limits on Amounts of Waiver Services

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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:

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:

Extended State Plan Service

Service Title:

Dental Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11070 dental services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Dental Services include maintenance or improvement of dental health as well as relief of pain and infection.

Dental 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. Dental services utilizing the telehealth delivery option are not an expansion of Dental services.

When telehealth is utilized to deliver Dental 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:

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Dentist
Individual	Dentists

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Dental Services

Provider Category:

Agency

Provider Type:

Dentist

Provider Qualifications

License *(specify):*

Non-restrictive licensure to practice dentistry in the State of Oklahoma. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure to practice dentistry in the adjacent state.

Certificate *(specify):*

Other Standard *(specify):*

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

Current SoonerCare General Provider Agreement - Special Provisions for Dentists, 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: Extended State Plan Service
Service Name: Dental Services

Provider Category:

Individual

Provider Type:

Dentists

Provider Qualifications

License *(specify):*

Non-restrictive licensure to practice dentistry in the State of Oklahoma. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure to practice dentistry in the adjacent state.

Certificate *(specify):*

Other Standard *(specify):*

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

Current SoonerCare General Provider Agreement - Special Provisions for Dentists, 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: 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:

Extended State Plan Service

Service Title:

Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11020 health assessment
Category 3:	**Sub-Category 3:**
09 Caregiver Support	09020 caregiver counseling and/or training
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. Nursing services typically include detailed assessment and documentation of the member's health needs, development and implementation of the nursing plan of care, training, and coordination of care with other medical professionals and service providers. Services are provided when nursing services furnished under SoonerCare plan limits are exhausted. The scope and nature of these services do not otherwise differ from nursing services furnished under SoonerCare.

Nursing services are provided on an intermittent or part-time basis and provided on a per visit basis. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence and may only be performed by a licensed nurse.

Nursing Services that are targeted toward training and evaluation are authorized for training members and their caregivers on the members unique health and medical needs.

Nursing 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. Nursing services utilizing the telehealth delivery option are not an expansion of Nursing services.

When telehealth is utilized to deliver Nursing 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:

Nursing services are provided when nursing services furnished under SoonerCare plan limits are exhausted. Additional visits are covered through the waiver for adults. These services are provided to children through SoonerCare, EPSDT.

Nursing services are limited to no more than three visits per day. When services are required for more than two consecutive hours, Nursing services are discontinued and Extended Duty Nursing services are authorized. Nursing services are not authorized in combination with Extended Duty Nursing services.

Nursing services that are targeted toward training and evaluation are billed in 15-minute increments and limited to 16 units (4 hours) per month, not to exceed 96 units per member's plan of care year, absent an exception per policy.

If the member needs additional services, the DHS/DDS Case Manager assists them to identify resources to meet their needs.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Registered Nurse
Agency	Licensed Practical Nurse
Agency	Home Health Agency
Individual	Registered Nurse

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Nursing

Provider Category:

Agency

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Current license by the Oklahoma Board of Nurse Registration and Nursing Education. When service is provided in a state adjacent to Oklahoma, provider must hold current licensure to practice as a Registered Nurse in the adjacent state.

Certificate *(specify):*

Other Standard *(specify):*

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: Extended State Plan Service
Service Name: Nursing

Provider Category:

Agency

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Current license by the Oklahoma Board of Nurse Registration and Nursing Education. When service is provided in a state adjacent to Oklahoma, provider must hold current licensure to practice as a Licensed Practical Nurse in the adjacent state.

Certificate *(specify):*

Other Standard *(specify):*

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: Extended State Plan Service
Service Name: Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Only medical professionals licensed to practice as a Registered Nurse or Licensed Practical Nurse in the state of Oklahoma may perform this service. When services are provided in a state adjacent to Oklahoma, medical professionals must hold current licensure to practice as a Registered Nurse or Licensed Practical Nurse in the adjacent state.

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

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: Extended State Plan Service
Service Name: Nursing

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Currently licensed to practice as a Registered Nurse in the state of Oklahoma. When service is provided in a state adjacent to Oklahoma, provider must hold current licensure to practice as a Registered Nurse in the adjacent state.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Health Care Authority

Frequency of Verification:

Ongoing

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:

Extended State Plan Service

Service Title:

Prescribed Drugs

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11060 prescription drugs
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Drugs in excess of SoonerCare limits for members who are not eligible for Part D of Medicare Prescription Drug, Improvement and Modernization Act of 2003, except when the drug is specifically excluded from Part D coverage.

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

Drugs in excess of SoonerCare limits are generic prescription drugs, seven (7) per member per month. SoonerCare covers six (6) prescription drugs. This means adult waiver members are eligible to receive up to a total of thirteen (13) prescription drugs per month, of which no more than three (3) can be brand name products. For waiver members who may require more than thirteen (13) prescriptions per month (brand name and generic products combined), or who may require more than three (3) brand name products per month, a request may be made on their behalf to have their additional prescription needs reviewed by the DHS/DDS Pharmacy Director.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Pharmacy

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Prescribed Drugs

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License *(specify):*

Oklahoma State Board of Pharmacy

Certificate *(specify):*

Other Standard *(specify):*

Current SoonerCare Provider Agreement for Pharmacy with the 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:

Agency Companion Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A living arrangement developed to meet the specific needs of the member which provides a shared living arrangement for supervision, supportive assistance, and training in daily living skills and integrates the member into the shared experiences of a family. This companion is an independent contractor of an agency, but is selected by the waiver member, and is usually a person with whom the member has a personal relationship.

Companions may assist or supervise the member with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The providers may also perform light housekeeping tasks, which are incidental to the care and supervision of the member. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

The person who serves as the companion is responsible for ongoing supports and is available whenever required by the member to successfully cope with the challenges that may occur in the life of the member.

Agency Companion services provide for therapeutic leave payment to enable the provider to retain personal care services during the time a member is out of his or her home for a period of time in excess of 24 hours without direct care staff because of hospitalization or other absence. Therapeutic leave must be authorized and documented in the plan of care.

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

A member may receive therapeutic leave for no more than 14 consecutive days per event, not to exceed 60 days per plan of care year.

Agency Companion services are not available to members in combination with Daily Living Support Services, Group Home or Specialized Foster Care Services.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Agency Companion Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Agency Companion Services

Provider Category:

Agency

Provider Type:

Agency Companion Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Current SoonerCare Provider Agreement with the Oklahoma Health Care Authority to provide Agency Companion services to OKDHS/DDSD HCBS waiver members.

Providers must complete the DHS/DDS sanctioned training curriculum. Individual provider staff must be specifically matched to the member and have an approved home profile per OAC 317:40-5-40. Staff must be at least 21 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 4 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:

Audiology Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Audiology Services include individual evaluation, treatment and consultation in hearing intended to maximize the member's auditory receptive abilities.

Audiology 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. Audiology services utilizing the telehealth delivery option are not an expansion of Audiology services.

When telehealth is utilized to deliver Audiology 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:

Audiology services are provided in accordance with the member's Individual Plan (Plan).

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Audiologists

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Audiology Services

Provider Category:

Individual

Provider Type:

Audiologists

Provider Qualifications

License *(specify):*

Licensure by the State Board of Examiners for Speech Pathology and Audiology,
59 O.S. Supp 2000, Section 1601 et seq. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure to practice audiology in the adjacent state.

Certificate *(specify):*

Other Standard *(specify):*

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

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: 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:

Daily Living Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Daily Living Supports are provided to members in order to enable them to reside successfully in certain community-based settings; accomplishing tasks they would normally do for themselves if they did not have a disability. These services are furnished to adults, who reside in a home that is leased or owned by the member receiving services. With prior approval by the Team, this service may be provided remotely.

Daily Living Supports provide up to eight (8) hours per day of direct support services. Assistance may go beyond tasks associated with activities of daily living to include assistance with cognitive tasks or the provision of services to prevent a member from harming him or herself.

Daily Living Supports includes house management expenses such as: 1) coordination of procurement of services and supplies, 2) developing and assuring emergency plans are in place and coordination of the overall safety in the home, and 3) assisting members with personal money management.

Daily Living Supports also include training developed to meet the specific needs of members as well as program supervision and oversight. The latter includes 24-hour availability of response staff to meet schedules or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

Additional individual payments will be made for other residential support services such as Habilitation Training Specialist and Homemaker services furnished to a member who is receiving Daily Living Supports who needs more than 8 hours per day of direct support services.

Daily Living Supports provide for therapeutic leave payment to enable the provider to retain personal care services during the time a member is out of his or her home for a period of time in excess of 24 hours without direct care staff because of hospitalization or other absence. Therapeutic Leave must be authorized and documented in the plan of care.

Daily Living Supports services are not available to members in combination with Agency Companion, Group Home or Specialized Foster Care services.

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

Payment for therapeutic leave may be made for up to 14 consecutive days per event, not to exceed 60 days per member's plan of care year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Daily Living Supports Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Daily Living Supports

Provider Category:

Agency

Provider Type:

Daily Living Supports Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Current SoonerCare Provider Agreement with the Oklahoma Health Care Authority to provide Daily Living Supports to DHS/DDS HCBS waiver members.

Providers must demonstrate the capability to manage a community support program by: agreement with the mission statement and guiding principles of DHS/DDS; capacity to provide Daily Living Supports; have a program for the recruitment, screening, training and retention of staff; financial capacity and fiscal accountability to provide services and supports on a long term basis; and a quality assurance program designed to evaluate all aspects of the providers Daily Living Supports.

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:

Environmental Accessibility Adaptations and Architectural Modification

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

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

Those architectural and environmental modifications and adaptations to the home, required by the member's plan of care, 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 DHS/DDS 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.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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:

OK 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:

Extended Duty Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Extended Duty Nursing services are services provided to a member that may only be performed by a licensed nurse and are required for more than two consecutive hours in the members home or other community setting. Services can include ongoing monitoring and evaluation of the members health status, as well as performance of skilled tasks that may only be performed by a licensed nurse. All services must be documented by the nurse and provided as ordered by the prescribing authority.

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

Extended Duty Nursing services are billed in 15 minute increments. No more than 24-hours (1,440 units) are allowed per member. Extended Duty Nursing services will not be authorized in combination with Nursing services which are intermittent or part-time. Extended Duty Nursing services will be discontinued in the event cost neutrality of the waiver is threatened.

If the member needs additional services, the DHS/DDS Case Manager assists them to identify resources to meet their needs.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Registered Nurse
Agency	Licensed Practical Nurse
Individual	Registered Nurse
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Extended Duty Nursing

Provider Category:

Agency

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Current license by the Oklahoma Board of Nurse Registration and Nursing Education. When service is provided in a state adjacent to Oklahoma, provider must hold current licensure to practice as a Registered Nurse in the adjacent state.

Certificate *(specify):*

Other Standard *(specify):*

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: Extended Duty Nursing

Provider Category:

Agency

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Current license by the Oklahoma Board of Nurse Registration and Nursing Education. When service is provided in a state adjacent to Oklahoma, provider must hold current licensure to practice as a Licensed Practical Nurse in the adjacent state.

Certificate *(specify):*

Other Standard *(specify):*

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: Extended Duty Nursing

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Current license as a Registered Nurse in the state of Oklahoma. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure to practice Registered Nursing in the adjacent state.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Health Care Authority

Frequency of Verification:

Ongoing

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Extended Duty Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Only medical professionals licensed to practice as a Registered Nurse or Licensed Practical Nurse in the state of Oklahoma may perform this service. When services are provided in a state adjacent to Oklahoma, medical professionals must hold current licensure to practice as a Registered Nurse or Licensed Practical Nurse in the adjacent state.

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

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:

Family Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09020 caregiver counseling and/or training
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Family Counseling, offered specifically to members and their natural, adoptive or foster family members, helps to develop and maintain healthy, stable relationships among all family members in order to support meeting the needs of the member. Emphasis is placed on the acquisition of coping skills by building upon family strengths. Knowledge and skills gained through family counseling services increase the likelihood that the member remains in or returns to his or her own home. Services are intended to maximize the member's/family's emotional/social adjustment and well-being. All family counseling needs are documented in the member's Individual Plan (Plan).

Family Counseling 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 Counseling services utilizing the telehealth delivery option are not an expansion of Family Counseling services.

When telehealth is utilized to deliver Family Counseling 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:

Individual counseling cannot exceed 400, 15 minute units per plan of care year. Group counseling cannot exceed 225, 30 minute units per plan of care year. Case Managers assist 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**

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	Licensed Professional Counselor
Individual	Clinical Social Worker
Individual	Licensed Marriage and Family Therapist
Individual	Psychologist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Counseling

Provider Category:

Individual

Provider Type:

Licensed Professional Counselor

Provider Qualifications

License *(specify):*

Licensure by the State Board of Health as a Licensed Professional Counselor, 59 O.S. Supp 2000 Section 1901 et seq. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure to practice counseling in the adjacent state.

Certificate *(specify):*

Other Standard *(specify):*

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

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: Family Counseling

Provider Category:

Individual

Provider Type:

Clinical Social Worker

Provider Qualifications

License *(specify):*

Licensure by the State Board of Licensed Social Workers, 59 O.S. Supp 2000 Section 1901 et seq. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure to practice social work in the adjacent state.

Certificate *(specify):*

Other Standard *(specify):*

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

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: Family Counseling

Provider Category:

Individual

Provider Type:

Licensed Marriage and Family Therapist

Provider Qualifications

License *(specify):*

Current licensure by the Oklahoma State Department of Health. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure to practice counseling in the adjacent state.

Certificate *(specify):*

Other Standard *(specify):*

Current SoonerCare provider agreement with the Oklahoma Health Care Authority to provide Family Counseling to DHS/DDS HCBS waiver members.

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: Family Counseling

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Licensure by the State Board of Examiners of Psychologists, 59 O.S. Supp 2000 Section 1352. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure to practice Psychology in the adjacent state.

Certificate *(specify):*

Other Standard *(specify):*

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

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:

Family Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 3:	**Sub-Category 3:**
10 Other Mental Health and Behavioral Services	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**

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	Qualified Individual
Agency	Family Training Agency or Business

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 the Oklahoma Health Care Authority to provide Family Training to DHS/DDS HCBS waiver members.

Current licensure, 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: 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 licensure, 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: 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:

Group Home Services

HCBS Taxonomy:

Category 1: 02 Round-the-Clock Services

Sub-Category 1: 02011 group living, residential habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Services are provided in licensed homes for up to 12 members. Services are developed in accordance with the needs of the member and include supports to assist members in acquiring, retaining and improving self-care, daily living, adaptive and leisure skills needed to reside successfully in a shared home within the community. Group Home services include full access to typical facilities in a home such as a kitchen with cooking facilities and small dining areas and provides for privacy and easy access to resources and unscheduled activities in the community. Members also have the opportunity for visitors at times of preference and convenience to them. Supports include supervision and oversight including 24-hour availability of response staff to meet schedules or unpredictable needs in a way that promotes maximum dignity and independence and to provide supervision, safety and security but does not include the time the member is in school or employed. Services are developed in accordance with the member's Individual Plan (Plan).

This service is not available to members in combination with Agency Companion, Daily Living Supports or Specialized Foster Care Services. Payments are not made for room and board, the cost of facility maintenance, upkeep or improvement.

In accordance with policy, HTS and group home service are not typically provided at the same time except when approved on a temporary basis. On occasion extraordinary circumstances arise requiring more intense one-on- one habilitation training than is provided through group home services. In these cases, authorization of a limited number short term HTS services for group home residents is required to prevent institutionalization and movement from group homes to other living arrangements. Once the issue is resolved, HTS services are discontinued. If the issue cannot be resolved, an orderly transition to an alternative living situation is planned to assure the member's health and welfare.

Prescribed Drugs, Specialized Medical Supplies and Assistive Technology, Home Health Care, Physical Therapy, Family Training, Nutrition, Skilled Nursing, Psychological, Speech Therapy, Family Counseling and Occupational Therapy services may be provided in the Group Home by providers with waiver Agreements when necessary to assure the member's health and welfare in the community.

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**

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	Group Home Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Group Home Services

Provider Category:

Agency

Provider Type:

Group Home Agency

Provider Qualifications

License *(specify):*

Current license by DHS, Title 10 O.S. Supp. 2000, Section 1430.1, et seq.

Certificate *(specify):*

Other Standard *(specify):*

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

Provider must meet 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: 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:

Intensive Personal Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Support services for members who need a more enhanced level of direct support in order to successfully reside in a community-based setting and to prevent institutionalization. This service builds upon the level of support provided by a Habilitation Training Specialist or Daily Living Supports staff by utilizing an additional staff person to provide assistance and training in self-care, daily living, recreation and habilitation activities.

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**

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	Intensive Personal Supports Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Intensive Personal Supports

Provider Category:

Agency

Provider Type:

Intensive Personal Supports Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Current SoonerCare Provider Agreement with the Oklahoma Health Care Authority to provide Daily Living Supports and Intensive Personal Supports services to DHS/DDS HCBS waiver members.

Intensive Personal Supports (IPS) providers must be at least 18 years old, successfully completed all required background checks in accordance with 56 O.S. § 1025.2 and complete the DHS/DDS sanctioned training curriculum. Agency must ensure providers are supervised by an individual having a minimum of 4 years of any combination of college level education and /or full-time equivalent experience in serving people with disabilities and ensure the provider receives training and oversight regarding specific methods to be used with the member to meet their complex behavioral needs.

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:

Nutrition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11040 nutrition consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Nutrition Services include dietary evaluation and consultation to members and their caregivers. Services are intended to maximize the member's nutritional health.

Nutrition 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. Nutrition services utilizing the telehealth delivery option are not an expansion of Nutrition services.

When telehealth is utilized to deliver Nutrition 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:

A unit is 15 minutes with a limit of 192 units per member's plan of care year.

If member needs additional services, the Case Manager assists them to identify resources to meet their needs.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Dietitians/Nutritionist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutrition Services

Provider Category:

Individual

Provider Type:

Dietitians/Nutritionist

Provider Qualifications

License *(specify):*

Licensure by the Oklahoma State Board of Medical Licensure and Supervision 59 O.S. Supp, Section 1721 et seq. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure as a Dietitian in the adjacent state.

Certificate *(specify):*

Certification as a Dietitian with the Commission on Dietetic Registration

Other Standard *(specify):*

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

Current SoonerCare General Provider Agreement - Special Provisions for Dietitians, 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: 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:

Occupational Therapy Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Occupational Therapy Services include the evaluation, treatment and consultation in leisure management, daily living skills, sensory motor, perceptual motor and mealtime assistance. Services are intended to contribute to the member's ability to reside and participate in the community. Services are rendered in any community setting as specified in the member's Individual Plan (Plan). The member's Plan must include a prescription by any licensed health care provider with appropriate prescriptive authority.

Assessment services for the purpose of home or vehicle modification may be provided through the waiver.

Occupational Therapy 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. Occupational Therapy services utilizing the telehealth delivery option are not an expansion of Occupational Therapy services.

When telehealth is utilized to deliver Occupational Therapy 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:

A unit is 15 minutes with a limit of 480 units per member's plan of care year.

If member needs additional services, the Case Manager assists them to identify resources to meet their needs.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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 Therapists

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Occupational Therapy Services

Provider Category:

Individual

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:

Ongoing through the claims 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:

Optometry

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Routine eye examination for vision correction. Routine eye examination for refraction error. Eyeglasses for vision correction and prevention of eye touching, thus avoiding the transfer of germs from the hands to the eyes.

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

Service will not be paid when such services have been provided to the member within the previous 24 month period. Limited to one pair of eyeglasses (lenses, frames and dispensing fee) per 24 month period. Service may be authorized to members age 21 and older. Members below age 21 may access service through SoonerCare.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Ophthalmologist
Individual	Optical Supplier

Provider Category	Provider Type Title
Individual	Optometrist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Optometry

Provider Category:

Individual

Provider Type:

Ophthalmologist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

American Board of Ophthalmology

Other Standard *(specify):*

SoonerCare Agreement to provide Optometry Services

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: Optometry

Provider Category:

Individual

Provider Type:

Optical Supplier

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

SoonerCare Agreement to provide Optometry Services

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: Optometry

Provider Category:

Individual

Provider Type:

Optometrist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Diplomate of the American Board of Optometry

Other Standard *(specify):*

SoonerCare Agreement to provide Optometry Services

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:

Physical Therapy Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Physical Therapy Services include the evaluation, treatment, and consultation in locomotion or mobility and skeletal and muscular conditioning, and maximize the member's mobility and skeletal/muscular well being. Services are provided in any community setting as specified in the member's Individual Plan (Plan). The member's Plan must include a prescription by any licensed health care provider with appropriate prescriptive authority.

Assessment services for the purpose of home or vehicle modification may be provided through the waiver.

Physical Therapy 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. Physical Therapy services utilizing the telehealth delivery option are not an expansion of Physical Therapy services.

When telehealth is utilized to deliver Physical Therapy 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:

A unit is 15 minutes with a limit of 480 units per member's plan of care year.

If member needs additional services, the Case Manager assists them to identify resources to meet their needs.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Physical Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physical Therapy Services

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: 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:

Physician Services (provided by a Psychiatrist)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11050 physician services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service provides outpatient psychiatric services provided by a licensed Psychiatrist and will be comprised of diagnosis, treatment and prevention of mental illness. These services will also include review, assessment and monitoring of psychiatric conditions, evaluation of the current plan of treatment and recommendations for a continued and/or revised plan of treatment and/or therapy, including required documentation. Psychiatrists may provide instruction and training to members, family members, case management staff and/or provider staff in the recognition of psychiatric illness and adverse reactions to medications.

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

A unit is 30 minutes, with a limit of 200 units per member's plan of care year.

If member needs additional services, the Case Manager assists them to identify resources to meet their needs.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Psychiatrist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Physician Services (provided by a Psychiatrist)

Provider Category:

Individual

Provider Type:

Psychiatrist

Provider Qualifications

License *(specify):*

Non-restrictive license to practice medicine in the State of Oklahoma. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure to practice psychiatry in the adjacent state.

M.D.-59 Oklahoma Statute Supplement Section 492 et. Seq.

D.O.-Oklahoma Statute Supplement98, Section 620 et seq.

Certificate *(specify):*

Certification by the Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in Psychiatry

Other Standard *(specify):*

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

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: 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:

Psychological Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10010 mental health assessment
Category 3:	**Sub-Category 3:**
10 Other Mental Health and Behavioral Services	10060 counseling
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Psychological Services include evaluation, psychotherapy, consultation and behavioral treatment. Services are provided in any community setting as specified in the member's Individual Plan (Plan). Services are intended to maximize a member's psychological and behavioral well-being. Services are provided in both individual and group (six person maximum) formats.

Psychological 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. Psychological services utilizing the telehealth delivery option are not an expansion of Psychological services.

When telehealth is utilized to deliver Psychological 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:

A minimum of 15 minutes for each individual encounter and 15 minutes for each group encounter and record documentation of each treatment session is included and required.

If member needs additional services, the Case Manager assists them to identify resources to meet their needs.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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	Psychologist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Psychological Services

Provider Category:

Individual

Provider Type:

Psychologist

Provider Qualifications

License *(specify):*

Non-restrictive license as a Psychologist by the Oklahoma Psychologist Board of Examiners or by the applicable state Board in the state where service is provided. 59 O.S. Supp Section 2000, 1352, et seq.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Health Care Authority

Frequency of Verification:

Ongoing through claims 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:

Remote Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Remote Supports (RS) is monitoring of an adult member; allowing for live, two-way communication with him or her in his or her residence or employment site, by monitoring staff using one or more of the systems below:

(1) live-video feed;
(2) live-audio feed;
(3) motion-sensing monitoring;
(4) radio-frequency identification;
(5) web-based monitoring;
(6) Personal Emergency Response System (PERS);
(7) global positioning system (GPS) monitoring devices; or
(8) any other device approved by the Developmental Disabilities Services (DDS) director or designee.

Remote Support services are intended to promote a member's independence. Services are provided in the member's home, family home, or employment site to reduce or replace services necessary to ensure the member's health and safety. Services are included in the member's Individual Plan (Plan) and arrangements for this service are made through the case manager.

Remote Support services are:

(A) based on the member's needs as documented and supported by the Plan and Person-Centered Assessment;
(B) the least-restrictive option and the member's preferred method to meet an assessed need;
(C) provided when all adult members of the household; his or her guardians, when applicable; and Personal Support Team (Team) certify agreement by providing written consent for the provision of RS services; and
(D) reviewed by the Team after 60-calendar days of initial installation to determine continued appropriateness of services.

Remote Support services are not a system to provide surveillance or for staff convenience.

HIPAA rules apply to all covered entities regarding HIPAA Privacy and Security. In the event of a data breach, then the appropriate entities within the State of Oklahoma are notified immediately to discuss action necessary.

When remote support involves the use of audio and/or video equipment that permits remote support staff to view activities and/or listen to conversations in the residence, the member who receives the service and each person who lives with the member will be fully informed of what remote support entails including, but not limited to, that the remote support staff will observe their activities and/or listen to their conversations in the residence, where in the residence the remote support will take place, and whether or not recordings will be made. If the member or a person who lives with the member has a guardian, the guardian shall consent in the Individual Plan. The member's case manager will document consent in the Plan. The member will have the ability to stop and recording activity at any time.

Remote supports allow for a member to choose the method of service delivery which best suits their needs. Teams will complete a risk assessment to ensure remote supports can help meet the needs of the member in a way that protects the right to privacy, dignity, respect, and freedom from coercion. The risk assessment will be reviewed and any issues will be addressed prior to the implementation of remote supports. This service is less intrusive than requiring the physical presence of another person to meet the needs of the member. Remote supports will promote and enhance the independence and self-reliance of the member, positively impacting the member's dignity, self-respect, respect from others and capacity for decision-making.

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.

Remote supports support community integration by encouraging the member to engage in community life as independently as possible, to be able to safely engage in activities in his or her home or in the community without relying on the physical presence of staff to accomplish those activities. In this way, the member will learn how to complete tasks and problem solve with the amount of support needed and desired. The member will have more self-confidence, autonomy and will be more likely to participate as an active member of the community. A back-up plan

to the remote supports will be in place so the member is not at risk when this support method is not desired. Members are encouraged to participate in community activities and can access generic or other supports as required to access the community if remote supports are not sufficient or appropriate to meet this need.

Remote support providers will ensure the member's health and safety by contacting a member's caregiver in the event a health or safety issue becomes evident while being monitored. The risk assessment and Individual Plan require the team to develop a plan to address health, safety and behavioral needs while remote supports are utilized so appropriate assistance can be provided. At least two emergency response staff are identified to respond to the member's location if there is an emergency need for in person staff support.

Remote Supports is not a substitute for face-to-face visits by DHS/DDS case management staff. Case Managers have face-to-face visits at least monthly with those receiving residential services. For those in their own home, a face-to-face contact occurs at least quarterly.

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

Remote Supports service is limited to 24 hours per day. The service is not provided simultaneously with Habilitation Training Specialist services, Homemaker services, Agency Companion services, Specialized Foster Care, Respite or Intensive Personal Supports services. Remote Supports service may be provided in conjunction with Daily Living Supports service, Supported Employment services and Prevocational services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Agency Providers of Remote Supports

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

Agency Providers of Remote Supports

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Current SoonerCare Provider Agreement with Oklahoma Health Care Authority to provide Remote Support services to DHS/DDS HCBS waiver members.

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Health Care Authority

Frequency of Verification:

Upon contract agreement renewal

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:	**Sub-Category 1:**
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

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:

Payment is not made for Respite Daily and Specialized Foster Care or Agency Companion services for the same member on the same date of 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**

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	Respite Care Provider
Agency	Group Home
Agency	Agency Companion
Individual	Respite Care Provider

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:

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:

Agency

Provider Type:

Group Home

Provider Qualifications

License *(specify):*

Current license by 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 Daily 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: 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: 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: 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 Foster Care also known as Specialized Family Home/Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized Foster Care (also known as Specialized Family Home/Care) is an individualized living arrangement offering up to 24 hour per day supervision, supportive assistance and training in daily living skills. Services are intended to allow a member to reside with a surrogate family. Services are provided to one to four members in the home in which the Specialized Foster Care provider resides. Four levels of specialized foster care, based upon the member's age and level of need as determined by the Team are: (1) maximum supervision, 18 years and under, for those member's with extensive needs; (2) close supervision, 18 years and under, for those members with moderate needs; (3) maximum supervision, 19 years and older, for members with extensive needs; and (4) close supervision, 19 years and older, for members with moderate needs. Members are required to pay room and board from their own funds.

Payments for residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

Specialized Foster Care services provide for therapeutic leave payment to enable the provider to retain personal care services during the time a member is out of his or her home for a period of time in excess of 24 hours without direct care staff because of hospitalization or other absence. Therapeutic leave must be authorized and documented in the plan of care.

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

Members who are in the custody of DHS and in an out-of-home placement funded by DHS Children and Family Services Division are not eligible for Specialized Foster Care.

Members may not simultaneously receive Specialized Foster Care and Group Home, Daily Living Supports and/or Agency Companion Services.

A member may receive therapeutic leave for no more than 14 consecutive days per event, not to exceed 60 days per plan of care year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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 Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Foster Care also known as Specialized Family Home/Care

Provider Category:

Individual

Provider Type:

Specialized Foster Care Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

OKDHS/DDSD Certification

Other Standard *(specify):*

SoonerCare Provider Agreement with the Oklahoma Health Care Authority to provide Specialized Foster Care services to DHS/DDS HCBS waiver members.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS/DDS

Frequency of Verification:

Twice yearly

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:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition (Scope):

Specialized Medical Supplies includes supplies specified in the member's plan of care not otherwise covered through 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.

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.

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:

- Assistive devices for members who are deaf or hard of hearing. Examples include visual alarms, telecommunication devices (TDD's), telephone amplifying devices and other devices for protection of health and safety.
- Assistive devices for members who are blind or visually impaired. Examples include tape recorders, talking calculators, lamps, magnifiers, Braille writers, paper and talking computerized devices and other devices for protection of health and safety.
- Augmentative/alternative communication and learning aids such as language boards, electronic communication devices and competence based cause and effect systems.
- Mobility positioning devices such as wheelchairs, travel chairs, walkers, positioning systems, ramps, seating systems, lifts, bathing equipment, specialized beds and specialized chairs.
- Orthotic and prosthetic devices such as braces and prescribed modified shoes.
- Environmental controls such as devices to operate appliances, use telephones or open doors.

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**

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	Durable Medical Equipment and/or Medical Supplies Dealer
Individual	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:

Agency

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.

Assistive Technology services are provided by an appropriate professional services provider with a current HCBS agreement with OHCA and current unrestricted licensure and certification with their professional board, when applicable.

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:

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.

Assistive Technology services are provided by an appropriate professional services provider with a current HCBS agreement with OHCA and current unrestricted licensure and certification with their professional board, when applicable.

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:

Speech Therapy Services

HCBS Taxonomy:

Category 1: | **Sub-Category 1:**

11 Other Health and Therapeutic Services | 11100 speech, hearing, and language therapy

Category 2: | **Sub-Category 2:**

Category 3: | **Sub-Category 3:**

Service Definition *(Scope):*

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

Speech Therapy includes evaluation, treatment and consultation in communication and oral motor-feeding activities provided to members. Services are intended to maximize the member's community living skills and may be provided in any community setting as specified in the member's Individual Plan (Plan).

Speech Therapy 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. Speech Therapy services utilizing the telehealth delivery option are not an expansion of Speech Therapy services.

When telehealth is utilized to deliver Speech Therapy 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:

One unit is 15 minutes with a limit of 288 units per member's plan of care year. The Case Manager assists the member to ensure needs are met through the service planning process.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Speech/Language Pathologists

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Speech Therapy Services

Provider Category:

Individual

Provider Type:

Speech/Language Pathologists

Provider Qualifications

License *(specify):*

Non-restrictive licensure as a Speech/Language Pathologist by the State Board of Examiners for Speech Pathology and Audiology, 59 O.S. Supp 2000, Section 1601 et seq. When services are provided in a state adjacent to Oklahoma, provider must hold current licensure to practice speech therapy in the adjacent state.

Certificate *(specify):*

Other Standard *(specify):*

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

Current SoonerCare General Provider Agreement - Special Provisions for Speech/Language Pathologists, 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:

Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Service offered in order to promote inclusion in the community, access to programs and services and participation in activities to enhance community living skills, specified in the plan of care. Transportation services under the waiver are offered in accordance with the member's Individual Plan (Plan). Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, will be utilized. Transportation services include adapted, non-adapted, and public transportation.

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

Adapted or non-adapted transportation limited to 14,400 miles per 12 months except in extenuating situations when person-centered planning identifies specific needs that require additional transportation for a limited period. Public transportation is limited to $25,000.00 per 12 months. Case Managers assist members to ensure their needs are met in the Team planning process. Alternatives such as ride sharing and other community supports can be used to ensure needs are met. Additional services can be planned and provided in extenuating circumstances.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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	Transportation Agency
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency

Provider Type:

Transportation Agency

Provider Qualifications

License *(specify):*

Operator must possess valid and current driver license for the state in which business is registered. Vehicle must meet applicable local and state requirements for vehicle licensure, insurance and capacity.

Certificate *(specify):*

Other Standard *(specify):*

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

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: Transportation

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Operator must possess valid and current Driver License for state in which they reside. Vehicle must meet applicable local and state requirements for vehicle licensure, insurance and capacity.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS/DDS

Frequency of Verification:

Annually

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 §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☒ **As a Medicaid state plan service under §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.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

DHS/DDS, the operating agency, conducts case management functions on behalf of waiver members.

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 full-time or part-time supportive assistance, health-related services or training to a person(s) with developmental disabilities or an intellectual disability. (b) Each provider requests a statewide criminal records check from the Oklahoma State Bureau of Investigation (OSBI) or Federal Bureau of Investigation (FBI) Identity History Summary Check which the employer is required or authorized to request pursuant to the provisions of this section. (c) DHS/DDS Quality Assurance Unit annually reviews a sample of the records of each contracted service provider to assure required documentation is on file for all applicable employees.

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; and, (c) the process for ensuring that mandatory screenings have been conducted. 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 DHS/DDS; (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 full-time or part-time supportive assistance, health-related services, or training to a person(s) with developmental disabilities or an intellectual disability. A Community Services Registry check is 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) Service provider agencies are required to conduct the pre-employment registry check. DHS/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.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Medicaid ICF/IID	
Group Homes	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

All residences are located in the community. Regulations for Group Homes require features compatible with the other residences in the surrounding neighborhood. Kitchens, bedrooms, bathrooms, and other rooms are like those in typical homes. Residents have Individual Plans that include recreation and leisure activities and employment consistent with their needs and interests. Each resident must be assured reasonable privacy and adequacy of space, storage, furnishings, bathrooms and other needs. Residents are encouraged to reflect their personal preferences in decorating and furnishing their individual living spaces. Residents participate in activities of daily living to the extent of their capabilities including cooking, laundry, shopping, and cleaning their rooms.

While we recognize that larger ICF-ID settings are not an environment like a home, respite is the only service allowed and is temporary in nature.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Medicaid ICF/IID

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Prescribed Drugs	☐
Group Home Services	☐
Intensive Personal Supports	☐
Prevocational Services	☐
Family Counseling	☐
Optometry	☐
Supported Employment	☐
Habilitation Training Specialist Services	☐
Audiology Services	☐
Environmental Accessibility Adaptations and Architectural Modification	☐
Occupational Therapy Services	☐
Speech Therapy Services	☐
Specialized Medical Supplies and Assistive Technology	☐
Physical Therapy Services	☐
Daily Living Supports	☐
Agency Companion Services	☐
Family Training	☐
Nutrition Services	☐
Dental Services	☐
Respite	☒

Waiver Service	Provided in Facility
Respite Daily	☐
Psychological Services	☐
Extended Duty Nursing	☐
Remote Supports	☐
Homemaker	☐
Transportation	☐
Specialized Foster Care also known as Specialized Family Home/Care	☐
Physician Services (provided by a Psychiatrist)	☐
Adult Day Health	☐
Nursing	☐

Facility Capacity Limit:

No capacity limit

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Group Homes

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Prescribed Drugs	☒
Group Home Services	☒
Intensive Personal Supports	☐
Prevocational Services	☐
Family Counseling	☒
Optometry	☐
Supported Employment	☐
Habilitation Training Specialist Services	☒
Audiology Services	☐
Environmental Accessibility Adaptations and Architectural Modification	☐
Occupational Therapy Services	☒
Speech Therapy Services	☒
Specialized Medical Supplies and Assistive Technology	☒
Physical Therapy Services	☒
Daily Living Supports	☐
Agency Companion Services	☐
Family Training	☒
Nutrition Services	☒
Dental Services	☐
Respite	☐
Respite Daily	☒
Psychological Services	☒
Extended Duty Nursing	☒
Remote Supports	☐
Homemaker	☐
Transportation	☐
Specialized Foster Care also known as Specialized Family Home/Care	☐
Physician Services (provided by a Psychiatrist)	☐
Adult Day Health	☐
Nursing	☒

Facility Capacity Limit:

4-12

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☐
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Specific ratios are not identified. Staffing must be adequate to meet each member's needs. The level of supervision needed is identified in the member's Individual Plan (Plan). Group home regulations require at least one staff on duty when any resident is at home unless the person has been assessed and their Plan specifies otherwise. Each group home has one person who is administratively responsible for the entire program. This person is in addition to direct care staff. Staff support and supervision is provided as needed for each resident of the home.

DHS/DDS Case Managers and Quality Assurance (QA) staff monitor the provision of appropriate staffing in accordance with the member's Plan. Contract provider agency surveys conducted by QA verify that adequate staffing is provided.

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 to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *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 legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure 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.*

☐ **Self-directed**

☐ **Agency-operated**

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 specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls 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.*

Legally responsible individuals, parents of minor children (biological or adoptive) or guardian of a minor child and the spouse of a waiver member, are not allowed to provide waiver services to a member for whom they are legally responsible.

Relatives/legal guardians who are not legally responsible for the member are prohibited from being paid as direct contract providers of waiver services except when they are the only available provider of covered services due to geographical remoteness or they are uniquely qualified to provide such services due to considerations such as language. Any non-legally responsible relative/legal guardian who serves as a paid provider must be qualified to provide the service and meet licensure/certification requirements. Also, the member's Team evaluates the member's needs and identifies any potential conflicts and the DHS/DDS Case Manager monitors the provision of services. 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 mother and father of an adult, brother, sister or child 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. Provider agencies must provide supervision and oversight of employees and ensure that claims are submitted only for services rendered. The Financial Management Service subagent ensures that claims are submitted only for services authorized in the self directed plan of care.

Relatives/legal guardians may provide services to include: Audiology, Dental, Respite, Agency Companion, Homemaker, Habilitation Training Specialist, Nutrition, Occupational Therapy, Physical Therapy, Physician, Speech Therapy, Transportation, Specialized Foster Care, Daily Living Supports, Intensive Personal Supports, Prevocational and Supported Employment. Non-legally responsible relatives/legal guardians are subject to the same service limits as any other provider of the same service.

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 payments are 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 OHCAs 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.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 new provider applications(denominator) for which the provider obtained appropriate licensure/certificate in accordance with state law and waiver provider qualifications prior to service provision (numerator).

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**	☒ **Annually**

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

Performance Measure:
Number and percent of providers(denominator) continuing to meet applicable licensure/certification following initial enrollment (numerator).

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:

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 (denominator) whose direct support staff had timely criminal background checks (numerator).

Data Source (Select one):

Provider performance monitoring
If 'Other' is selected, specify:
Provider performance monitoring (2300)

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:

Performance Measure:
Number and percent of direct support agency providers (denominator) providing required supervision, guidance and oversight of paraprofessional staff providing direct service (numerator).

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
Provider performance monitoring (2328)(4121)(4301)(5141)

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 non-licensed/non-certified provider applicants (denominator), by provider type, who initially and continually met waiver provider qualifications(numerator).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider applications

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(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 direct support agency providers (denominator) whose direct support staff had timely registry checks (numerator).

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
Provider performance monitoring (2300)

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:

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:
The state implements it's policies and procedures by verifying the number and percent of direct support agency providers (denominator) meeting basic training requirements (Foundation training, effective teaching course, First Aid, CPR and medication administration training, if medications are administered)in accordance with state requirements and the approved waiver (numerator).

Data Source (Select one):
Provider performance monitoring

If 'Other' is selected, specify:

Provider performance monitoring (2307)

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**	☒ **Annually**

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

Performance Measure:
The state implements its policies and procedures by verifying the number and percent of direct support agency providers (denominator) meeting annual training requirements (12 hours of the required re-certification classes in First Aid, CPR and medication administration training, if medications are administered) in accordance with state requirements and the approved waiver (numerator).

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
Provider performance monitoring (2315)

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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. 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**
	☐ **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.

(a) All Prevocational Services and Supported Employment Services combined may not exceed $43,815.00 per 12 month period; (b) The limit was determined based on 30 hours of employment activities. (c) Don't anticipate a need for an adjustment; (d) There are no exceptions, however, other services are available, i.e. vocational rehabilitation and other generic resources; (e) Other services are available, i.e. vocational rehabilitation and other generic resources; (f) Limit is stated in policy and in provider Agreements.

☐ **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 and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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 ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Refer to Main, Attachment #2

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual 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 *(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 Bachelors Degree in a human services field and one year of experience working directly with persons with developmental and/or intellectual disabilities; or possession of a valid permanent Oklahoma license as approved by the Oklahoma Board of Nursing to practice professional nursing and one year working directly with persons with developmental and/or intellectual disabilities.

☐ **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. *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.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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.

Prior to the member's Individual Plan (Plan) meeting, the Case Manager consults the member and his/her legal guardian and/or the member's advocate if there is one. The purpose is to discuss the member's preferences, goals, and desires for the next year and guides the direction and course of the Plan. 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. The pre-meeting allows the member another opportunity to express himself/herself regarding the services and supports he/she has received during the previous year and the personal desires for the upcoming year. Person-centered planning is used in all phases of the service development process.

Using the Person-Centered Planning approach, a Plan is developed by the Personal Support Team (Team), which includes the member, his or her Case Manager, the 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 people selected by the member who know and work with the member or whose participation is necessary to achieve the outcomes desired by the member receiving services. 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 planning process reflects the member's cultural considerations, is provided in plain language, in an accessible manner, and provides needed language services or aides. 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. 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. 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; and, (g) how and when the plan is updated, including when the participant's needs change. 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), 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 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 may include others. The selection of these additional Team 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 is no larger than is necessary to plan for and implement the services needed to achieve the member's desired outcomes. The Team 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 members assure early intervention and prevention by the Team 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, medical, social, and functional assessments are completed prior to the development of an initial Plan. The medical, 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 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 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;

(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 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 makes maximum use of services which are available to all citizens and assures the Team identifies all needed services and supports.

The Case Manager assures the services and supports developed by the Team 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 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.

Each Team 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 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, or which violates DHS policy or accepted standards of professional practice, the Case Manager notifies that Team member by letter that his or her services on the Team 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.

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 intellectual disability, 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 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 and participant health and welfare; (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 of choice of providers and to assure the health and welfare of the member is protected. Case Managers assess services rendered to each member at least quarterly. For all members receiving residential supports, an annual health review is performed by a DHS/DDS Registered Nurse. This health review is also used by the Case Manager to determine if health objectives listed in the service plan are being achieved, or if modifications to the Plan are indicated. Case Managers have face-to-face visits at least monthly with those receiving residential services. For those in their own home, a face-to-face contact occurs at least quarterly. Monitoring may also be conducted by DHS/DDS case management and Quality Assurance staff, utilizing HIPAA compliant phone calls or video conferencing.

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 Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
Number and percent of member's records reviewed (denominator) who had Individual Plans that included a back-up plan (numerator).

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
Operating agency performance monitoring (Area Survey Q3a)

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 a 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 (denominator), using tools and checklists developed by DHS/DDS Quality Assurance Unit, who had Individual Plans that were adequate and appropriate to their needs and personal goals as indicated in the assessment(s) (numerator).

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
Operating agency performance monitoring (Area Survey Q3)

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 a 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 records reviewed (denominator) who had Individual Plans that contain methods to address safety and health risks and needs. (numerator).

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
Operating agency performance monitoring (Area Survey Q7c)

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 a 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: 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.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

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 and addendums reviewed (denominator) who had a review of progress by the Case Manager as required by policy ensuring implementation of the Individual Plan (numerator).

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
Operating agency performance monitoring (Area Survey Q5a)

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 a 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 (denominator), using tools and checklists developed by DHS/DDS Quality Assurance Unit, with a situation identified in which a Team (as described in Appendix D-1:c) meeting was held within 30 days of the identification or notification of the need for a change (numerator).

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
Operating agency performance monitoring (Area Survey Q2)

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 a 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 (denominator) who had service

plans updated/revised within 40 days of the notification of the change in the waiver member's needs (numerator).

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
Operating agency performance monitoring (Area Survey Q1b)

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 a 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 (denominator) who had a quarterly summary of progress on assigned outcomes submitted by the provider agency as specified by policy (numerator).

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
Provider performance monitoring (1103)

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 a 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 (denominator) who had service plans updated/reviewed at least annually (numerator).

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Operating agency performance monitoring (Area Survey Q1a)

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 a 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**	☒ **Annually**

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

Performance Measure:
Number and percent of member's records reviewed (denominator) whose Individual Plan meeting was held on or before the date of the plan of care expiration (numerator).

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
Operating agency performance monitoring (Area Survey Q1)

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 a 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: 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 (denominator) who received the type, amount, duration, scope and frequency of the services identified in the Individual Plan (numerator).

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
Operating agency performance monitoring (Area Survey Q5)

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 a 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 (denominator) who received from the direct support provider agency the type, amount, duration, scope and frequency of the services identified in the Individual Plan (numerator).

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
Provider performance monitoring (1102)

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 a 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 (denominator) who had Individual Plans that included a description of each of the services and supports included in the member's plan of care, including the amount, duration and frequency of service (numerator).

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Operating agency performance monitoring (Area Survey Q7b)

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 a 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**

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:

e. ***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 waiver member records reviewed (denominator) with an appropriately completed and signed freedom of choice form that specified choice was offered between/among waiver services and providers (numerator).

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
Operating agency performance monitoring (Area Survey Q8)

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 a 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 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.4 and a.i.d.2 are collected from 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 1000-5000 in the Data Source field represent the DHS/DDS performance tool identifier.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. 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.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **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.

Appendix E: Participant Direction of Services

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. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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. DHS/DDS Case Managers also provide an explanation of the form and process as well as assisting in the process. The form also includes a section requiring the choice between HCBS waiver services and institutional care and acknowledges the freedom of choice of qualified providers. This form is reviewed annually and a copy is maintained electronically in the DDS case management database. 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 DHS/DDS authorization system or in the case of denial or termination, by the DHS system. This notice includes information regarding the method of requesting a Fair Hearing. In addition, any adverse action relating to SoonerCare eligibility generates a notice from the DHS Information Management System, which includes information related to request of a Fair Hearing. The DHS/DDS Case Manager assists the member or their representative in requesting and preparing for a Fair Hearing as requested. The notice specifies that services may continue during the pendency 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 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**

b. 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.

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**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The Oklahoma Department of Human Services Office of Client Advocacy (DHS/OCA) is responsible for the operation of the grievance system.

c. 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 DHS 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 DHS.

DHS/OCA has established policies that 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 Directors review of an appealed grievance. Each DHS/DDS Area office 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 member 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 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 DHS/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, notice of right to appeal, and the designation of a LGC who is responsible for implementation of the provider agencys grievance process. Timelines for response to grievances range from five working days for first level resolution to ten working days for the provider agencys Board of Directors (or Appeals Committee designated by the Board).

DHS/OCA ensures the quality of grievance systems by establishing minimum standards and through an ongoing monitoring program. The Advocate General and DHS/OCA staff have immediate and unlimited access to members, staff, and provider agency files, records, and documents relating to grievance procedures and practices.

The DHS/OCA grievance system in no way undermines the member's right to request a Fair Hearing. DHS policy provides that DHS/DDS members are granted Hearings if the application for services is denied; when resources are sufficient for initiation of HCBS waiver services 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 DHS/OCA and are addressed in accordance with DHS/OCA policies and procedures (OAC 340:2-5-61). DHS/DDS Case Managers assure that members understand that filing a grievance or making a complaint is not a prerequisite or substitute for a Fair Hearing. Case Managers provide information annually to members, their Advocates and Guardians regarding both processes. They are also available to assist in requesting a Fair Hearing or filing a grievance.

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 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 include: 1) suspected maltreatment (abuse, neglect, sexual abuse or sexual exploitation) of a member; 2) threatened or attempted suicide by a member; 3) death of a member; 4) an unplanned hospital admission of a member; 5) unplanned admission to a psychiatric facility of a member; 6) a medication event resulting in emergency medical treatment for a member; 7) law enforcement involvement in a situation concerning a member; 8) property loss of more than $500.00; 9) a member is missing; and 10) a highly restrictive procedure is used with a member. The service provider ensures the incident report is submitted electronically to DDS.

NON-CRITICAL INCIDENT REPORTING REQUIREMENTS: The procedures for reporting incidents considered as non-critical are identical to those described for critical incidents except that immediate notification is not required. Incidents Reports must be provided to DHS/DDS case management within three business days of observing or discovering the incident. Incident Reports are required under the following circumstances: an injury to a member; an unplanned health related event involving a member; physical aggression by a member; fire setting by a member; deliberate harm to an animal by a member; property loss of less than $500 involving a member; a vehicle accident involving a member; the suspension, termination or removal of a member's program including employment, and a medication event not involving the emergency room treatment of a member. 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. Within DHS, four divisions are responsible for receipt, evaluation and response to critical incidents. The divisions responsible are Child Protective Services (CPS)(maltreatment of children), Office of Client Advocacy (OCA)(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), Adult Protective Services (APS)(maltreatment of vulnerable adults and self neglect)and Developmental Disabilities Services (DDS)(incidents identified in Appendix G-1-a that do not constitute maltreatment).

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 DHS, 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 time frames 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) is the entity to which reports are submitted. Within DHS, three divisions are responsible for receipt, evaluation and response to critical incidents. The divisions responsible are Child Welfare Services (CWS)(maltreatment of children), Office of Client Advocacy (OCA)(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), and Developmental Disabilities Services (DDS)(incidents identified in Appendix G-1-a that do not constitute maltreatment).

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 staffing 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 face down 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)*

b. Medication Management and Follow-Up

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.

Prescribers have primary responsibility for monitoring members' medication regimens, as defined by State statute and applicable licensing requirements. Prescription medications, as defined in OAC 340:100-1-2, are administered or used only as ordered by a healthcare provider who is licensed by law to prescribe a drug intended to be filled, compounded, or dispensed by a Pharmacist. Approval for a member to use or be administered a nonprescription medication, as defined in OAC 340:100-1-2, is received in writing from the member's licensed healthcare provider at least annually. Use of psychotropic and behavior modifying medications must follow requirements listed in policies OAC 340:100-5-26.1 and 340:100-5-32.

Both DHS/DDS and contracted service provider staff perform secondary monitoring of medication administration. Reviews are conducted on a monthly basis for members in a residential setting and on a quarterly basis for members in a non-residential setting when medications are administered by paid staff. Contracted service provider staff that have been specifically trained to administer medications perform daily monitoring including the members' response to the administered medication. Any abnormal or unusual signs or symptoms are reported on form Referral Form for Examination or Treatment (DDS-5) for the healthcare provider's review at the time of the medical appointment. The completed form Referral Form for Examination or Treatment (DDS-5), including the healthcare provider's recommendations, is forwarded to the case manager. If any unusual physical signs or symptoms are reported, further review is performed by DHS/DDS staff.

For members receiving community residential supports and group home services per OAC 340:100-5-22.1 and OAC 340:100-6, a clinical pharmacy review by a clinical pharmacist is performed upon request by the member or Team and when indicated by a change in health status. The completed pharmacy review is provided to the case manager and to the healthcare provider(s) for review. The case manager submits a clinical pharmacy review annually and/or as needed per policy.

For non-residential members, a clinical pharmacy review by a clinical pharmacist will be performed upon request of a Team member or clinician participating with the Team.

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.

Nursing staff monitor member medication regimens through the performance of Health Care Summaries and Medication Administration Record reviews. DHS/DDS further requires that all members receive an annual medical report, performed by a licensed healthcare provider, to ensure that a medical professional with prescriptive authority reviews individual medication regimens at least annually.

Additionally, the DHS/DDS Nurse monitors medication administration through the performance of annual Heath Care Summaries and Medication Administration Record Reviews for all members receiving residential services.

The case manager and service provider review all medical incident reports and the case manager holds a team meeting to revise the member's medication support plan if needed.

A clinical pharmacy review by a clinical pharmacist will be performed for members receiving community residential supports per OAC 340:100-5-22.1 and OAC 340:100-6 annually and/or as required by policy.

For non-residential members, a clinical pharmacy review by a clinical pharmacist will be performed upon request of a Team member or clinician participating with the Team.

The completed pharmacy review is provided to the case manager and to the healthcare provider(s) for review.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

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)*

ii. 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).

Only those contracted service provider staff members who have completed an approved training program in medication administration, as specified in OAC 340:100-3-38, are permitted to administer medications. Oklahoma Statue 56-1020 specifies the safe storage and administration of medications by non-licensed community service staff. Health Care Coordinators must also be trained as specified in policy OAC 340:100-5-26. DHS/DDS Quality Assurance staff monitor compliance with this training on an annual basis.

All individuals administering or assisting in the administration of medications to members are subject to the requirements specified in OAC 340:100-5-32. This policy outlines the responsibilities of service providers who are contracted, licensed, or funded through an HCBS waiver or DHS/DDS State funds and their employees, who administer medication or assist with a medication support plan for a person receiving community services, including employment or vocational service providers. Each member and their support Team develop an individual medication support plan to identify participation by the member in his or her own medication administration and to specify the supports needed by the member for administering, storing, and monitoring medication. The members' medication support plan assures that the members'involvement, together with the designed supports implemented by staff, result in a safe program of medication administration. The Team revises the medication support plan to provide safety and meet the members' medication support needs if a medication change or monitoring by the DHS/DDS Case Manager, contracted service provider Program Coordinator, DHS/DDS Nurse or DHS/DDS Quality Assurance Unit staff or other person reveals a concern with the members' medication supports.

iii. 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:

An Incident Report and follow-up must be completed when a medication event (error) occurs as specified in OAC 340:100-3-24. Contract service providers are required to submit an electronic Incident Report to the DHS/DDS Case Manager.

Provider staff administering medications to members are required to perform daily documentation of medications administered using a Medication Administration Record (MAR), as well as document the response to any PRN medications administered. Any abnormal or unusual signs or symptoms are reported on a form for the healthcare provider's review at the time of the medical appointment. The completed form, including the healthcare provider's recommendations, is forwarded to the case manager. All incidents involving medications are documented by the provider and submitted electronically through the provider reporting system to the case manager for review and follow-up as needed. Medication events that require emergency medical treatment are required by policy to be reported electronically within one business day. Primary provider responsibilities in monitoring and reporting medication administration are defined in Oklahoma policy OAC 340:100-5-32, Medication Administration.

For non-critical incidents involving medication events, the Incident Report is required to be sent to the member's Case Manager within three business days of the incident.

(b) Specify the types of medication errors that providers are required to *record:*

As specified in OAC 340:100-3-34, a medication event includes:

- dosage at the wrong time;
- missed dose;
- wrong dose;
- wrong medicine;
- wrong route; or
- the person refused the medication.

Additionally, any medication event that requires emergency medical treatment for a member is defined as a critical incident, and the contract service provider is required to document these events and notify the DHS/DDS Case Manager within one business day of observing or discovering the incident.

(c) Specify the types of medication errors that providers must *report* to the state:

All medication events are reported to the State, along with follow-up action initiated by the service provider.

○ **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:

iv. 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.

DHS/DDS is responsible for monitoring the performance of waiver service providers in the administration of medications to waiver members. Medication administration is reviewed as part of the annual Quality Assurance monitoring of providers. The data is reviewed to identify trends and areas for improvement. Recommendations are developed for systemic improvement.

Members receive an annual medical report, performed by a licensed healthcare provider, to ensure that a medical professional with prescribing authority reviews individual medication regimens at least annually. Contract service provider staff trained to administer medications perform daily monitoring including members' response to administered medication. Any abnormal or unusual signs or symptoms are reported on a form for the healthcare provider's review at the time of the medical appointment. The completed form, including the healthcare provider's recommendations, is forwarded to the case manager. If any unusual physical signs or symptoms are reported, further review is performed by DHS/DDS staff.

The Case Manager monitors the members' medication regimen, as well as any problems associated with medication management, through quarterly site visits and home records review, ongoing review of submitted documentation of medication administration and oversight performed by contract service provider staff, and review of incident reports. Additionally, the DHS/DDS Nurse monitors medication administration through the performance of Health Care Summaries and Medication Administration Record Reviews for all members receiving residential supports. Health Care Summaries and Medication Administration Record Reviews are performed at least annually or when indicated by a change in health status.

A clinical pharmacy review by a clinical pharmacist will be performed for Members receiving community residential supports and group home services per OAC 340:100-5-22.1 and OAC 340:100-6 annually and/or as required by policy. For non-residential members, a clinical pharmacy review by a clinical pharmacist will be performed upon request of a Team member or clinician participating with the Team.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

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 (denominator) where the

member (and/or family or legal guardian) received information/education about how to identify and report abuse, neglect, exploitation and unexplained death as specified in the approved waiver (numerator) (Individual Plans completed after 07-01-10)

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
Operating agency performance monitoring (Area Survey Q12)

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 a 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 unexplained deaths (denominator) for which mortality reviews were completed in order to prevent future incidents (numerator).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Certificates of Death, Medical Examiner Reports, Critical Incident Reports

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 Critical Incident Reports that identify abuse, neglect, or exploitation (denominator) for which follow-up was completed by the team (numerator).

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**

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 abuse, neglect, exploitation, and unexplained death incidents (denominator) reviewed/investigated within the required timeframe (numerator).

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 substantiated abuse, neglect, exploitation, and unexplained death incidents (denominator) where required/ recommended follow-up (safety plans, corrective action plans, provider sanctions, etc) was completed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Mortality reviews and Abuse, Neglect, Exploitation database

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:

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 medication errors (denominator) reviewed by case management staff as required by the State (numerator).

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 of medication errors (denominator)that did not result in emergency medical treatment out of the total number of medication errors (numerator).

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 critical incidents (denominator) that were reviewed by the

Incident Management Committee to ensure proper action was taken to prevent further incidents (numerator).

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**

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 reviewed medication errors (denominator) where follow-up was completed as required to ensure resolution and prevention of future errors (numerator).

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's records reviewed where the provider was required (denominator) and acted immediately to remedy any situation which posed a risk to the health, well-being, safety or provision of specified service (numerator).

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
Provider performance monitoring (1517)

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(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 a 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 member's records reviewed where case management intervention was required (denominator) and occurred to address issues related to incident reports and health and welfare risks if necessary (numerator).

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:
Operating agency performance monitoring (Q10)

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 a 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 critical incidents (denominator) for which follow-up was completed by case management staff as required by the State (numerator).

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:

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 (denominator) for whom the provider completed required critical incident reports (numerator).

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
Provider performance monitoring (1519)

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 a 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 critical incidents (denominator) that were reported within required timeframes as specified in the approved waiver (numerator).

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:

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 (denominator) that were free from the use of prohibited behavior management procedures (numerator).

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
Provider performance monitoring (1304)

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 a 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 containing protective intervention protocols (denominator) with restrictive procedures approved by the Statewide Human Rights and Behavior Review Committee (numerator).

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
1301

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 a 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):*

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:
Number and percent of member's records reviewed (denominator) that had an annual medical report (numerator).

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 a 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 (denominator) for whom the provider was required by policy to identify an appropriately trained health care coordinator to ensure implementation and coordination of health care services for members (numerator).

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
Provider performance monitoring (3011)

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 a 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:

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.

Reference to "Q" numbers or numbers in the 1000-5000 series in the Data Source field represent the DHS/DDS 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 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 performance measures in Appendix G. PMs a.i.a.1, and a.i.b.6 are collected from the Quality Assurance Agency Monitoring survey tool. PMs a.i.b.5, a.i.b.8, a.i.c.1, a.i.d.2 are collected from the Quality Assurance Provider Performance survey tool. PM a.i.d.1 is 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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. 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. 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 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 §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 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 Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, 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 Quality Improvement Strategy 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 Quality Improvement Strategy. 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 improvementin 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 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.

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*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **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 DDSD 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.

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 looks 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 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 providers are required to submit the 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 review these audits and follow-up on any findings relative to waiver programs. In addition, service providers are surveyed at least once each year by the DHS/DDS Quality Assurance Unit, who review documentation related to service delivery to confirm billed charges on a random sample.

Effective July 1, 2020 all providers of Personal Care services to members receiving 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 the provider of the service resides in the home with the member, EVV is not required. 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 service that requires EVV will be denied unless the claim has been submitted by the aggregator. Quality Assurance will audit EVV claims as part of their provider performance surveys to ensure that the EVV system is being used as required and that providers are complying with the EVV policies and procedures.

All plans of care are subject to the approval of OHCA, the Medicaid Agency, and are made available by DHS/DDS, 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. OHCA performs a financial audit of the waiver service providers as part of a more comprehensive provider audit process. The financial audit reviews claims in comparison with documentation of service delivery and in comparison with service plan authorization. Service delivery documentation is selected and reviewed by random sample, 95% confidence level with a +/- 5% margin of error. For the provider financial audit, members are selected at random for the programmatic review with 95% confidence level with a +/- 5% margin of error. All claims for services delivered to them over a one quarter period are reviewed. OHCA Program Integrity and Accountability department is responsible for conducting financial audits on an annual basis.

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.

All providers must have an active contract agreement in order for reimbursement to be made. Providers with an active contract agreement are issued provider identification numbers. The Medicaid Management Information System (MMIS), the state's claims payment system, has edit checks that will deny payments to inactive provider identification numbers.

A report of financial audit is made available to the provider and includes findings and recommendations/requirements for plan of correction/improvement of provider business process, if any. Frequency of provider claims errors from the initial review may lead to additional sampling. If the audit detects a pattern of inappropriate billing, a referral is made to Program Integrity and Accountability for review and further investigation of the providers billing practices.

The Program Integrity (PI) unit uses Business Objects to pull paid claim information from iCE. The data is mined using Access and Excel to look for any inappropriate billing patterns. If potential inappropriate billing is discovered verification is done by looking in iCE and reaching out to agency contacts to ensure PI is correct. Once the division has confirmed potential error, error letters with a spreadsheet of findings are sent to the provider. The provider may then send in a check for overpayment, request the overpayment be recovered from future billings, or if they do not agree they may file an informal reconsideration or a formal appeal. Once all steps are completed, if findings are still an error, the overpayments

will be recouped/repaid and overpayments reported on the quarterly CMS64.

Program Integrity processes and reviews all referrals/complaints related to potential fraud, waste, or abuse. While reviewing and analyzing referrals, data (including but not limited to paid and denied claims, prior authorizations, member and provider information) is reviewed and compared to the complaint. All information is presented in a case selection process to determine if an audit will be conducted and the scope and specifications of that audit (e.g., member limited or full review; statistical sample or universe; desk or onsite).

Most audits are desk reviews; however, Program Integrity conducts audits both through desk and onsite review. During the analysis of claims and evaluating overall risk of fraud, waste, or abuse, it is determined if the audit will be a desk or onsite review. Potential risks that could warrant an onsite audit include, but are not limited to, the risk for records to be created or altered for the audit, records not being submitted as complete if requested for a desk review or noncompliance with a records request, potential of record destruction, and potential for practice abandonment. The difference between the two types is the way records are collected. In a desk review, the provider is notified via mail of the audit and is given a list of members, dates of service, and required documentation which must be submitted for review. An onsite audit may be announced (2-week notice) or unannounced (no notice). A detailed listing of members, dates of service, and required documentation is given to the provider and all documentation must be submitted to the audit team during the onsite audit. For both audit types, records are reviewed in office and the provider is notified by mail through an audit report of the results and any identified overpayment amount.

The Member Audit team includes the eligibility cases for the waiver in the Medicaid Eligibility Quality Control audit, and additional audits as determined necessary to ensure accuracy of eligibility for sampled claims. Case sampling is random, except that the universes are stratified to ensure non-MAGI eligibility cases have a sufficient number of reviews. The Oklahoma State Auditor and Inspector also reviews claims associated with non-MAGI eligibility, and includes claims that fall within this waiver.

A prevalence of erroneous provider claim errors resulting from eligibility issues would be reviewed in more detail by selecting a universe containing the cases associated with the waiver, and selecting a random sample for review. Provider specific issues would be referred to appropriate Program Integrity provider units.

Audits do not differ based on the service. Audits follow the same audit process to verify services billed were performed by appropriately qualified personnel and in compliance with all state and federal regulations/policies.

The results of the audit are sent to the provider through an error letter (audit report) with a detailed spreadsheet of claims in error.

The state requires that the provider repay the state for the overpayment.

Identified overpayments are reported quarterly on the CMS-64 to return the federal share of the inappropriate claims.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

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 in this sub-assurance include all Appendix I performance measures for waiver

actions submitted before June 1, 2014.)

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 payment errors (denominator) remediated in accordance with OHCA policy following error identification through provider performance review (numerator).

Data Source *(Select one):*
Provider performance monitoring
If 'Other' is selected, specify:
Provider performance monitoring (2201)

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 a 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 reviewed waiver claims submitted for Federal Financial Participation (FFP) (denominator) that are specified in the member's service plan (numerator).

Data Source *(Select one):*
Provider performance monitoring
If 'Other' is selected, specify:
Provider performance monitoring (2201)

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 a 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 reviewed claims (denominator)coded and paid in accordance

with waiver reimbursement methodology specified in the approved waiver and only for services rendered (numerator).

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***

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 service claims reviewed (denominator) that were submitted for members who were enrolled in the waiver on the date that the service was delivered (numerator).

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Comparison of claims with enrollment file

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 (denominator) resulting from MMIS edit checks performed to determine whether the submitted waiver claims were authorized in the member service plan as specified in the approved waiver (numerator).

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***

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

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:
Total number and percent of waiver claims approved (denominator) using the appropriate rate methodology (numerator).

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 reviewed (denominator) that followed and remained consistent with the approved rate methodology through the five-year waiver cycle(numerator).

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***	☐ ***Weekly***	☒ ***100% Review***

Agency		
☒ ***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 1000-5000 series in the Data Source field represent the DHS/DDS 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 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 performance measures in a 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 record, provider audits, and claims records which are checked at 100%

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. 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 OKDHS/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. Further steps, such as additional staff training, may be identified/offered to provider agencies in order to correct negative trends. 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. Rates are given final consideration and approval by the OHCA Board.

Rates for waiver services are set by one of the methodologies below.

1) Method One - Utilizing the Medicaid Rate: When a waiver service is the same as a Medicaid service for which a fee schedule has been established, the current Medicaid rate is utilized. The fee schedule may be accessed at https://oklahoma.gov/ohca/providers/claim-tools/fee-schedule.html. Services utilizing the Medicaid Rate are:

» Audiology
» Dental
» Nutrition
» Prescription Drugs
» Optometry

The State affirms that all waiver services provided under the State Plan are provided under the same rate as the State Plan rate for all providers.

2)Method Two - 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. 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:

» Adult Day
» Agency Companion
» Daily Living Supports
» Extended Duty Nursing
» Family Counseling
» Group Home
» Habilitation Training Specialist
» Homemaker
» Intensive Personal Supports
» Nursing
» Occupational Therapy
» Physical Therapy
» Physician Services (provided by a Psychiatrist)
*» Prevocational**
» Psychological
» Remote Supports
» Respite Care
» Specialized Foster Care
*» Specialized Medical Supplies and Assistive Technology***
» Speech Therapy
*» Supported Employment****
» Transportation

All fixed rates established by operating agency received the 4% increase due to a Legislative appropriation. 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.

3) Method Three - 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. Fox 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.

** 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 the 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. A Quality Payment may be earned and paid for additional/atypical effort of the provider that results in a member working towards competitive integrated employment. The base unit of the quality payment is $500.00 and is authorized based on the member making an incremental move along the continuum from less integrated settings toward more integrated settings, in the direction of competitive integrated employment, after 15 days of employment for a minimum of 15 hours weekly. Up to three units of quality payments for a total of $1500 will be made based on the member making up to 3 moves in the direction of competitive integrated employment in one plan year. The state engaged in a technical assistance program with a Medicaid Innovation Accelerator Program (National Opinion Research Center or NORC) to develop a value-based payment solution (the Quality Payment) to encourage more community integrated employment opportunities in 2019 and early 2020. The $500.00 unit rate was developed in 2020 based on input from stakeholders. 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.

Nursing and Extended Duty Nursing:

The rate-setting methodology is identified above in the fixed-rate method outlined in method two.

The rate setting methodologies for nursing and extended duty nursing services were reviewed in 2006. Two separate and unrelated circumstances prompt this request for a rate change. First, the utilization of the per visit code for service plan development participation and assessment/evaluation has become increasingly problematic. This is because the time period of these encounters are extremely variable, yet, the code allows for only a fixed rate reimbursement. Consequently, this fixed rate often and increasingly fails to cover nursing costs incurred. The second event was the 55% increase, effective October 1, 2005, in the Medicaid State Plan Home Health benefit skilled nurse rate to which the waiver skilled nurse rates had previously been linked in policy. The rate methodology used to set the revised Medicaid State Plan Home Health benefit skilled nurse rate was based upon Medicare Home Health benefit rate tables and protocols. However, the skilled nursing services provided under the waiver and the Medicare program are not the same and agency providers of skilled nursing services under DDS are not required to be Medicare certified providers and usually are not. In addition, changes in Medicaid State Plan Personal Care (SPPC) policy shift responsibility for skilled nursing assessment and service planning from state DHS nurses to provider agency nurses.

Effective January 2016 under the direction of CMS the code G0154 was split into two codes to differentiate levels of nursing services provided during a hospice stay and/or home health episode of care. The G0299 code represents direct skilled nursing services of an RN and G0300 represents direct skilled nursing services of an LPN. At that time the State identified that the rate for the codes were sufficient and there was no need to consider a rate change at that time. In addition, OHCA agreed to maintain parity between waiver services programs in their core in-home services. SB1600 appropriated funds for a 7% provider rate increase effective July 1, 2018.

Additional information may be found 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 Oklahomas 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 Oklahomas 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 providers billing practices. Identified overpayments are reported quarterly on the 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.

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.

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

I-3: Payment (7 of 7)

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.

Oklahoma does not restrict reassignment to any specific agency.

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:

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 §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 §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 §1915(b)/§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 §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 ?1115/?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 ?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 textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §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 §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 Oklahomas HCBS Waiver Programs is from General Fund Appropriations from the State Legislature made to two State Agencies. The 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 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 the DHS for the State share dollars for all Waiver services (except prescription drugs) for which service provider claims were processed/paid. Through an inter-Agency transfer, these State share funds are then deposited into the OHCAs general fund. The transfer of these funds represents a repayment to the OHCA, since the OHCA had 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 mechanism.

☐ ***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.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded.

All members are subject to a co-payment for prescription drugs unless the member is pregnant or the drug is used for family planning. Co-payments are not applied to other non-pharmaceutical waiver services.

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.

The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge
Prescribed Drugs	***Amount:*** *$0.00 for preferred generics.* *$0.65 for cost of $0.00-$10.00* *$1.20 for cost of $10.01-$25.00* *$2.40 for cost of $25.01-$50.00* *$3.50 for cost of $50.01 or more* ***Basis:*** *$0.00 for preferred generics.* *$0.65 for prescriptions having a Medicaid allowable payment of $0.00-$10.00. $1.20 for prescriptions having a Medicaid allowable payment of $10.01-$25.00. $2.40 for prescriptions having a Medicaid allowable payment of $25.01-$50.00 and $3.50 for prescriptions having a Medicaid allowable paynment of $50.01 or more. Co-payments are for members age 21 and older.*

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.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (select one):

- (●) ***There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.***
- ( ) ***There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.***

Specify the cumulative maximum and the time period to which the maximum applies:

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	133196.47	6928.12	140124.59	174086.37	5738.06	179824.43	39699.84
2	137028.11	7066.68	144094.79	177568.09	5852.82	183420.91	39326.12
3	139659.60	7208.01	146867.61	181119.45	5969.87	187089.32	40221.71
4	142367.60	7352.17	149719.77	184741.83	6089.26	190831.09	41111.32
5	145146.47	7499.22	152645.69	188436.66	6211.04	194647.70	42002.01

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	640	640
Year 2	640	640
Year 3	640	640
Year 4	640	640
Year 5	640	640

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 1-5 are based on Form 372 for FY18.

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:*

Factor D estimates for rates for waiver year 1 was made by using approved rates from waiver year 5 of the most amendment prior to the waiver renewal, effective September 1, 2020.

The number of users for waiver year 1 is based on WY5 of the current waiver application as enrollment remains steady.

Average units per user for waiver year 1 were based on the utilization identified in Form 372 for FY18.

The number of users and average number of units per user for the Supported Employment – Quality Payment service are estimated based on a state-funded pilot of this service that began on October 1, 2020. The state engaged in a technical assistance program with a Medicaid Innovation Accelerator Program (National Opinion Research Center or NORC) to develop a value-based payment solution (the Quality Payment) in 2019 and early 2020. The $500.00 unit rate was developed in 2020 based on input from stakeholders. The rate was approved by the OHCA State Plan Amendment Review Committee (SPARC) and Board.

CMS approved the use of Remote Supports by the state via an Appendix K effective January 2020. The number of users and average number of units per user for the Remote Supports service are estimated based on the experience with this service the state has had during the Public Health Emergency. The cost per unit rate was developed and based on a review of similar states who use remote supports and input from stakeholders. The rate was approved by the OHCA SPARC and Board.

Factor D estimates for rates for waiver year 2 was made based on Form 372 for FY20. A 2% annual increase was applied to Factor D estimates for waiver years 3-5. The 2% annual increase was based on the average Consumer Price Index (CPI) from the Bureau of Labor Statistics for 2017 and 2018. The CPI was 2.1% for 2017 and 1.9% for 2018. The average CPI for this timeframe was 2%.

The number of users from FY18 Form 372 was used to estimate the number of users for waiver years 2 to 5 except for new services for which there is no available 372 data. The number of users for new services added effective July 1, 2021 (Supported Employment - Quality Payment, Remote Supports) for waiver years 2 through 5 were retained from the current waiver renewal projections.

The average number of units per user from FY18 Form 372 was used to estimate the average number of units per user for waiver years 2 to 5 except for new services for which there is no available 372 data. The average number of units per user for new services added effective July 1, 2021 (Supported Employment - Quality Payment, Remote Supports) for waiver years 2 through 5 were retained from the current waiver renewal projections.

The number of users for Optometry Services added effective July 1, 2022 for waiver year 2-5 is based on estimates that 64% of the adult population in the U.S. require corrective lenses.

Average number of units per user for Optometry Services for waiver years 2-5 is based on the limit of 1 exam and 1 pair of corrective lenses per user every 2 years.

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' for year 1 is based on Form 372 for FY18.

Factor D' for year 2 is based on Form 372 for FY18 and increased annually by 2% for years 3 - 5. The 2% annual increase was based on the average Consumer Price Index (CPI) from the Bureau of Labor Statistics for 2017 and 2018. The CPI was 2.1% for 2017 and 1.9% for 2018. The average CPI for this timeframe was 2%.

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 for year 1 is based on Form 372 for FY18.

Factor G for year 2 is based on Form 372 for FY18 and increased annually by 2% for years 3 - 5. The 2% annual increase was based on the average Consumer Price Index (CPI) from the Bureau of Labor Statistics for 2017 and 2018. The CPI was 2.1% for 2017 and 1.9% for 2018. The average CPI for this timeframe was 2%.

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' for year 1 is based on Form 372 for FY18.

Factor G' for year 2 is based on Form 372 for FY18 and increased annually by 2% for years 3 - 5. The 2% annual increase was based on the average Consumer Price Index (CPI) from the Bureau of Labor Statistics for 2017 and 2018. The CPI was 2.1% for 2017 and 1.9% for 2018. The average CPI for this timeframe was 2%.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

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	
Adult Day Health	
Habilitation Training Specialist Services	
Homemaker	
Prevocational Services	
Respite	
Supported Employment	
Dental Services	
Nursing	
Prescribed Drugs	
Agency Companion Services	
Audiology Services	
Daily Living Supports	
Environmental Accessibility Adaptations and Architectural Modification	
Extended Duty Nursing	
Family Counseling	
Family Training	
Group Home Services	
Intensive Personal Supports	
Nutrition Services	
Occupational Therapy Services	
Optometry	
Physical Therapy Services	
Physician Services (provided by a Psychiatrist)	
Psychological Services	
Remote Supports	
Respite Daily	
Specialized Foster Care also known as Specialized Family Home/Care	
Specialized Medical Supplies and Assistive Technology	

Waiver Services	
Speech Therapy Services	
Transportation	

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
Adult Day Health Total:						65694.72
Adult Day Health	15 min.	16	1974.00	2.08	65694.72	
Habilitation Training Specialist Services Total:						39156974.24
Habilitation Training Specialist Services	1 hour	538	4322.00	16.84	39156974.24	
Homemaker Total:						89680.00
Homemaker	1 hour	5	1121.00	16.00	89680.00	
Prevocational Services Total:						1129982.74
Prevocational Services	1 hour	257	382.00	11.51	1129982.74	
Respite Total:						111168.00
Respite	1 hour	18	386.00	16.00	111168.00	
Supported Employment Total:						2892467.00
Individual	1 hour	70	325.00	18.38	418145.00	
Group	1 hour	190	918.00	14.10	2459322.00	
Quality Payment	Event	15	2.00	500.00	15000.00	
Dental Services Total:						284665.05
Dental Services	Visit	417	9.00	75.85	284665.05	
				GRAND TOTAL:		85245742.76
				Total Estimated Unduplicated Participants:		640
				Factor D (Divide total by number of participants):		133196.47
				Average Length of Stay on the Waiver:		355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Total:						**551594.10**
Training and Evaluation	15 min.	10	99.00	15.09	**14939.10**	
Skilled Nursing	Visit	19	538.00	52.50	**536655.00**	
Prescribed Drugs Total:						**138040.00**
Prescribed Drugs	1 Rx. Each	56	29.00	85.00	**138040.00**	
Agency Companion Services Total:						**1119047.40**
Agency Companion Services	Per day	27	335.00	123.72	**1119047.40**	
Audiology Services Total:						**711.72**
Audiology Services	Per service	9	2.00	39.54	**711.72**	
Daily Living Supports Total:						**31053422.40**
Daily Living Supports	Per day	562	345.00	160.16	**31053422.40**	
Environmental Accessibility Adaptations and Architectural Modification Total:						**15366.40**
Environmental Accessibility Adaptations and Architectural Modification	Per item	20	1.00	768.32	**15366.40**	
Extended Duty Nursing Total:						**1155358.36**
Extended Duty Nursing	15 min.	13	13147.00	6.76	**1155358.36**	
Family Counseling Total:						**7247.10**
Family Counseling	15 min.	5	87.00	16.66	**7247.10**	
Family Training Total:						**211162.80**
Individual Training	Session	20	58.00	157.83	**183082.80**	
Group Training	Session	180	12.00	13.00	**28080.00**	
Group Home Services Total:						**128306.88**
Group Home Services	Per day	3	276.00	154.96	**128306.88**	
Intensive Personal Supports Total:						**2952153.04**

GRAND TOTAL:	**85245742.76**
Total Estimated Unduplicated Participants:	**640**
Factor D (Divide total by number of participants):	**133196.47**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Intensive Personal Supports	1 hour	103	1702.00	16.84	2952153.04	
Nutrition Services Total:						382354.56
Nutrition Services	15 min.	327	42.00	27.84	382354.56	
Occupational Therapy Services Total:						190611.20
Occupational Therapy Services	15 min.	116	79.00	20.80	190611.20	
Optometry Total:						0.00
Exam	Per Item	0	0.00	0.01	0.00	
Corrective lenses	Per Item	0	0.00	0.01	0.00	
Physical Therapy Services Total:						269568.00
Physical Therapy Services	15 min.	216	60.00	20.80	269568.00	
Physician Services (provided by a Psychiatrist) Total:						627.50
Physician Services (provided by a Psychiatrist)	30 min.	5	2.00	62.75	627.50	
Psychological Services Total:						280280.00
Psychological Services	15 min.	130	100.00	21.56	280280.00	
Remote Supports Total:						53611.20
Remote Supports	15 min.	9	2920.00	2.04	53611.20	
Respite Daily Total:						4158.40
Out of Home	Per day	3	10.00	119.60	3588.00	
In Home	Per day	2	5.00	57.04	570.40	
Specialized Foster Care also known as Specialized Family Home/Care Total:						120294.72
Specialized Foster Care also known as Specialized Family Home/Care	Per day	6	357.00	56.16	120294.72	
Specialized Medical Supplies and Assistive Technology Total:						927516.03
Specialized					758638.26	

GRAND TOTAL:	8524574.76
Total Estimated Unduplicated Participants:	640
Factor D (Divide total by number of participants):	133196.47
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical Supplies	Per item	309	2958.00	0.83		
Assistive Technology	Per item	103	41.00	39.99	168877.77	
Speech Therapy Services Total:						114895.20
Speech Therapy Services	15 min.	98	60.00	19.54	114895.20	
Transportation Total:						1838784.00
Transportation	1 mile	600	5024.00	0.61	1838784.00	
				GRAND TOTAL:		8524574.76
				Total Estimated Unduplicated Participants:		640
				Factor D (Divide total by number of participants):		133196.47
				Average Length of Stay on the Waiver:		355

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
Adult Day Health Total:						66958.08
Adult Day Health	15 min.	16	1974.00	2.12	66958.08	
Habilitation Training Specialist Services Total:						39947554.48
Habilitation Training Specialist Services	1 hour	538	4322.00	17.18	39947554.48	
Homemaker Total:						91473.60
Homemaker	1 hour	5	1121.00	16.32	91473.60	
Prevocational Services Total:						1152562.76
Prevocational Services	1 hour	257	382.00	11.74	1152562.76	
Respite Total:						113391.36
				GRAND TOTAL:		87697993.06
				Total Estimated Unduplicated Participants:		640
				Factor D (Divide total by number of participants):		137028.11
				Average Length of Stay on the Waiver:		355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite	1 hour	18	386.00	16.32	113391.36	
Supported Employment Total:						2949722.10
Individual	1 hour	70	325.00	18.75	426562.50	
Group	1 hour	190	918.00	14.38	2508159.60	
Quality Payment	Event	15	2.00	500.00	15000.00	
Dental Services Total:						290369.61
Dental Services	Visit	417	9.00	77.37	290369.61	
Nursing Total:						562624.20
Training and Evaluation	15 min.	10	99.00	15.39	15236.10	
Skilled Nursing	Visit	19	538.00	53.55	547388.10	
Prescribed Drugs Total:						140800.80
Prescribed Drugs	1 Rx. Each	56	29.00	86.70	140800.80	
Agency Companion Services Total:						1141388.55
Agency Companion Services	Per day	27	335.00	126.19	1141388.55	
Audiology Services Total:						725.94
Audiology Services	Per service	9	2.00	40.33	725.94	
Daily Living Supports Total:						31673870.40
Daily Living Supports	Per day	562	345.00	163.36	31673870.40	
Environmental Accessibility Adaptations and Architectural Modification Total:						15673.80
Environmental Accessibility Adaptations and Architectural Modification	Per item	20	1.00	783.69	15673.80	
Extended Duty Nursing Total:						1179285.90
Extended Duty Nursing	15 min.	13	13147.00	6.90	1179285.90	
Family Counseling						7390.65

GRAND TOTAL:	87697993.06
Total Estimated Unduplicated Participants:	640
Factor D (Divide total by number of participants):	137028.11
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Family Counseling	15 min.	5	87.00	16.99	**7390.65**	
Family Training Total:						**674008.40**
Individual Training	Session	20	58.00	160.99	**186748.40**	
Group Training	Session	180	20.00	135.35	**487260.00**	
Group Home Services Total:						**130873.68**
Group Home Services	Per day	3	276.00	158.06	**130873.68**	
Intensive Personal Supports Total:						**3011757.08**
Intensive Personal Supports	1 hour	103	1702.00	17.18	**3011757.08**	
Nutrition Services Total:						**390045.60**
Nutrition Services	15 min.	327	42.00	28.40	**390045.60**	
Occupational Therapy Services Total:						**194460.08**
Occupational Therapy Services	15 min.	116	79.00	21.22	**194460.08**	
Optometry Total:						**40340.16**
Exam	Per Item	168	1.00	93.58	**15721.44**	
Corrective lenses	Per Item	168	1.00	146.54	**24618.72**	
Physical Therapy Services Total:						**275011.20**
Physical Therapy Services	15 min.	216	60.00	21.22	**275011.20**	
Physician Services (provided by a Psychiatrist) Total:						**640.10**
Physician Services (provided by a Psychiatrist)	30 min.	5	2.00	64.01	**640.10**	
Psychological Services Total:						**285870.00**
Psychological Services	15 min.	130	100.00	21.99	**285870.00**	
Remote Supports Total:						**57816.00**
Remote Supports	15 min.	9	2920.00	2.20	**57816.00**	
Respite Daily Total:						**4241.50**

GRAND TOTAL:	**87697993.06**
Total Estimated Unduplicated Participants:	**640**
Factor D (Divide total by number of participants):	**137028.11**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Out of Home	Per day	3	10.00	121.99	3659.70	
In Home	Per day	2	5.00	58.18	581.80	
Specialized Foster Care also known as Specialized Family Home/Care Total:						122693.76
Specialized Foster Care also known as Specialized Family Home/Care	Per day	6	357.00	57.28	122693.76	
Specialized Medical Supplies and Assistive Technology Total:						949174.87
Specialized Medical Supplies	Per item	309	2958.00	0.85	776918.70	
Assistive Technology	Per item	103	41.00	40.79	172256.17	
Speech Therapy Services Total:						117188.40
Speech Therapy Services	15 min.	98	60.00	19.93	117188.40	
Transportation Total:						2110080.00
Transportation	1 mile	600	5024.00	0.70	2110080.00	

GRAND TOTAL:	87697993.06
Total Estimated Unduplicated Participants:	640
Factor D (Divide total by number of participants):	137028.11
Average Length of Stay on the Waiver:	355

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
Adult Day Health Total:						68221.44
Adult Day Health	15 min.	16	1974.00	2.16	68221.44	
Habilitation Training						40738134.72

GRAND TOTAL:	89382147.07
Total Estimated Unduplicated Participants:	640
Factor D (Divide total by number of participants):	139659.60
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialist Services Total:						
Habilitation Training Specialist Services	1 hour.	538	4322.00	17.52	**40738134.72**	
Homemaker Total:						**93323.25**
Homemaker	1 hour	5	1121.00	16.65	**93323.25**	
Prevocational Services Total:						**1176124.52**
Prevocational Services	1 hour	257	382.00	11.98	**1176124.52**	
Respite Total:						**115684.20**
Respite	1 hour	18	386.00	16.65	**115684.20**	
Supported Employment Total:						**3008721.40**
Individual	1 hour	70	325.00	19.12	**434980.00**	
Group	1 hour	190	918.00	14.67	**2558741.40**	
Quality Payment	Event	15	2.00	500.00	**15000.00**	
Dental Services Total:						**296149.23**
Dental Services	Visit	417	9.00	78.91	**296149.23**	
Nursing Total:						**573868.64**
Training and Evaluation	15 min.	10	99.00	15.70	**15543.00**	
Skilled Nursing	Visit	19	538.00	54.62	**558325.64**	
Prescribed Drugs Total:						**143610.32**
Prescribed Drugs	1 Rx. Each	56	29.00	88.43	**143610.32**	
Agency Companion Services Total:						**1164272.40**
Agency Companion Services	Per day	27	335.00	128.72	**1164272.40**	
Audiology Services Total:						**740.52**
Audiology Services	Per service	9	2.00	41.14	**740.52**	
Daily Living Supports Total:						**32307890.70**
Daily Living Supports	Per day				**32307890.70**	

GRAND TOTAL:	**89382147.07**
Total Estimated Unduplicated Participants:	**640**
Factor D (Divide total by number of participants):	**139659.60**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		562	345.00	166.63		
Environmental Accessibility Adaptations and Architectural Modification Total:						**15987.20**
Environmental Accessibility Adaptations and Architectural Modification	Per item	20	1.00	799.36	**15987.20**	
Extended Duty Nursing Total:						**1201504.33**
Extended Duty Nursing	15 min.	13	13147.00	7.03	**1201504.33**	
Family Counseling Total:						**7538.55**
Family Counseling	15 min.	5	87.00	17.33	**7538.55**	
Family Training Total:						**677743.60**
Individual Training	Session	20	58.00	164.21	**190483.60**	
Group Training	Session	180	20.00	135.35	**487260.00**	
Group Home Services Total:						**133490.16**
Group Home Services	Per day	3	276.00	161.22	**133490.16**	
Intensive Personal Supports Total:						**3071361.12**
Intensive Personal Supports	1 hour	103	1702.00	17.52	**3071361.12**	
Nutrition Services Total:						**397736.64**
Nutrition Services	15 min.	327	42.00	28.96	**397736.64**	
Occupational Therapy Services Total:						**198308.96**
Occupational Therapy Services	15 min.	116	79.00	21.64	**198308.96**	
Optometry Total:						**40340.16**
Exam	Per Item	168	1.00	93.58	**15721.44**	
Corrective lenses	Per Item	168	1.00	146.54	**24618.72**	
Physical Therapy Services Total:						**280454.40**
Physical Therapy Services	15 min.	216	60.00	21.64	**280454.40**	

GRAND TOTAL:	**89382147.07**
Total Estimated Unduplicated Participants:	**640**
Factor D (Divide total by number of participants):	**139659.60**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physician Services (provided by a Psychiatrist) Total:						**652.90**
Physician Services (provided by a Psychiatrist)	30 min.	5	2.00	65.29	**652.90**	
Psychological Services Total:						**291590.00**
Psychological Services	15 min.	130	100.00	22.43	**291590.00**	
Remote Supports Total:						**57816.00**
Remote Supports	15 min.	9	2920.00	2.20	**57816.00**	
Respite Daily Total:						**4326.30**
Out of Home	Per day	3	10.00	124.43	**3732.90**	
In Home	Per day	2	5.00	59.34	**593.40**	
Specialized Foster Care also known as Specialized Family Home/Care Total:						**125157.06**
Specialized Foster Care also known as Specialized Family Home/Care	Per day	6	357.00	58.43	**125157.06**	
Specialized Medical Supplies and Assistive Technology Total:						**961777.95**
Specialized Medical Supplies	Per item	309	2958.00	0.86	**786058.92**	
Assistive Technology	Per item	103	41.00	41.61	**175719.03**	
Speech Therapy Services Total:						**119540.40**
Speech Therapy Services	15 min.	98	60.00	20.33	**119540.40**	
Transportation Total:						**2110080.00**
Transportation	1 mile	600	5024.00	0.70	**2110080.00**	
				GRAND TOTAL:		**89382147.07**
				Total Estimated Unduplicated Participants:		**640**
				Factor D (Divide total by number of participants):		**139659.60**
				Average Length of Stay on the Waiver:		355

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
Adult Day Health Total:						**69800.64**
Adult Day Health	15 min.	16	1974.00	2.21	**69800.64**	
Habilitation Training Specialist Services Total:						**41551967.32**
Habilitation Training Specialist Services	1 hour.	538	4322.00	17.87	**41551967.32**	
Homemaker Total:						**95172.90**
Homemaker	1 hour	5	1121.00	16.98	**95172.90**	
Prevocational Services Total:						**1198704.54**
Prevocational Services	1 hour	257	382.00	12.21	**1198704.54**	
Respite Total:						**117977.04**
Respite	1 hour	18	386.00	16.98	**117977.04**	
Supported Employment Total:						**3068175.70**
Individual	1 hour	70	325.00	19.51	**443852.50**	
Group	1 hour	190	918.00	14.96	**2609323.20**	
Quality Payment	Event	15	2.00	500.00	**15000.00**	
Dental Services Total:						**302078.97**
Dental Services	Visit	417	9.00	80.49	**302078.97**	
Nursing Total:						**585317.52**
Training and Evaluation	15 min.	10	99.00	16.01	**15849.90**	
Skilled Nursing	Visit	19	538.00	55.71	**569467.62**	
Prescribed Drugs Total:						**146484.80**
Prescribed Drugs	1 Rx. Each	56	29.00	90.20	**146484.80**	
Agency Companion Services Total:						**1187518.05**
Agency Companion Services					**1187518.05**	

GRAND TOTAL:	**91115261.65**
Total Estimated Unduplicated Participants:	**640**
Factor D (Divide total by number of participants):	**142367.60**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Per day	27	335.00	131.29		
Audiology Services Total:						**755.28**
Audiology Services	Per service	9	2.00	41.96	**755.28**	
Daily Living Supports Total:						**32953544.40**
Daily Living Supports	Per day	562	345.00	169.96	**32953544.40**	
Environmental Accessibility Adaptations and Architectural Modification Total:						**16307.00**
Environmental Accessibility Adaptations and Architectural Modification	Per item	20	1.00	815.35	**16307.00**	
Extended Duty Nursing Total:						**1225431.87**
Extended Duty Nursing	15 min.	13	13147.00	7.17	**1225431.87**	
Family Counseling Total:						**7690.80**
Family Counseling	15 min.	5	87.00	17.68	**7690.80**	
Family Training Total:						**681548.40**
Individual Training	Session	20	58.00	167.49	**194288.40**	
Group Training	Session	180	20.00	135.35	**487260.00**	
Group Home Services Total:						**136156.32**
Group Home Services	Per day	3	276.00	164.44	**136156.32**	
Intensive Personal Supports Total:						**3132718.22**
Intensive Personal Supports	1 hour	103	1702.00	17.87	**3132718.22**	
Nutrition Services Total:						**405702.36**
Nutrition Services	15 min.	327	42.00	29.54	**405702.36**	
Occupational Therapy Services Total:						**202249.48**
Occupational Therapy Services	15 min.	116	79.00	22.07	**202249.48**	
Optometry Total:						**40340.16**

GRAND TOTAL:	**91115261.65**
Total Estimated Unduplicated Participants:	**640**
Factor D (Divide total by number of participants):	**142367.60**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Exam	Per Item	168	1.00	93.58	15721.44	
Corrective lenses	Per Item	168	1.00	146.54	24618.72	
Physical Therapy Services Total:						286027.20
Physical Therapy Services	15 min.	216	60.00	22.07	286027.20	
Physician Services (provided by a Psychiatrist) Total:						665.90
Physician Services (provided by a Psychiatrist)	30 min.	5	2.00	66.59	665.90	
Psychological Services Total:						297440.00
Psychological Services	15 min.	130	100.00	22.88	297440.00	
Remote Supports Total:						57816.00
Remote Supports	15 min.	9	2920.00	2.20	57816.00	
Respite Daily Total:						4412.90
Out of Home	Per day	3	10.00	126.92	3807.60	
In Home	Per day	2	5.00	60.53	605.30	
Specialized Foster Care also known as Specialized Family Home/Care Total:						127663.20
Specialized Foster Care also known as Specialized Family Home/Care	Per day	6	357.00	59.60	127663.20	
Specialized Medical Supplies and Assistive Technology Total:						983563.48
Specialized Medical Supplies	Per item	309	2958.00	0.88	804339.36	
Assistive Technology	Per item	103	41.00	42.44	179224.12	
Speech Therapy Services Total:						121951.20
Speech Therapy Services	15 min.	98	60.00	20.74	121951.20	
Transportation Total:						2110080.00
Transportation	1 mile	600	5024.00	0.70	2110080.00	

GRAND TOTAL:	91115261.65
Total Estimated Unduplicated Participants:	640
Factor D (Divide total by number of participants):	142367.60
Average Length of Stay on the Waiver:	355

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
Adult Day Health Total:						**71064.00**
Adult Day Health	15 min.	16	1974.00	2.25	**71064.00**	
Habilitation Training Specialist Services Total:						**42389052.28**
Habilitation Training Specialist Services	1 hour	538	4322.00	18.23	**42389052.28**	
Homemaker Total:						**96574.15**
Homemaker	1 hour	5	1121.00	17.23	**96574.15**	
Prevocational Services Total:						**1223248.04**
Prevocational Services	1 hour	257	382.00	12.46	**1223248.04**	
Respite Total:						**120339.36**
Respite	1 hour	18	386.00	17.32	**120339.36**	
Supported Employment Total:						**3129374.20**
Individual	1 hour	70	325.00	19.90	**452725.00**	
Group	1 hour	190	918.00	15.26	**2661649.20**	
Quality Payment	Event	15	2.00	500.00	**15000.00**	
Dental Services Total:						**308121.30**
Dental Services	Visit	417	9.00	82.10	**308121.30**	
Nursing Total:						**597082.96**
Training and Evaluation	15 min.	10	99.00	16.33	**16166.70**	
Skilled Nursing					**580916.26**	

GRAND TOTAL:	**92893739.19**
Total Estimated Unduplicated Participants:	**640**
Factor D (Divide total by number of participants):	**145146.47**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Visit	19	538.00	56.83		
Prescribed Drugs Total:						**149424.24**
Prescribed Drugs	1 Rx. Each	56	29.00	92.01	**149424.24**	
Agency Companion Services Total:						**1211306.40**
Agency Companion Services	Per day	27	335.00	133.92	**1211306.40**	
Audiology Services Total:						**770.40**
Audiology Services	Per service	9	2.00	42.80	**770.40**	
Daily Living Supports Total:						**33612770.40**
Daily Living Supports	Per day	562	345.00	173.36	**33612770.40**	
Environmental Accessibility Adaptations and Architectural Modification Total:						**16633.00**
Environmental Accessibility Adaptations and Architectural Modification	Per item	20	1.00	831.65	**16633.00**	
Extended Duty Nursing Total:						**1251068.52**
Extended Duty Nursing	15 min.	13	13147.00	7.32	**1251068.52**	
Family Counseling Total:						**7843.05**
Family Counseling	15 min.	5	87.00	18.03	**7843.05**	
Family Training Total:						**685434.40**
Individual Training	Session	20	58.00	170.84	**198174.40**	
Group Training	Session	180	20.00	135.35	**487260.00**	
Group Home Services Total:						**138880.44**
Group Home Services	Per day	3	276.00	167.73	**138880.44**	
Intensive Personal Supports Total:						**3195828.38**
Intensive Personal Supports	1 hour	103	1702.00	18.23	**3195828.38**	
Nutrition Services Total:						**413805.42**

GRAND TOTAL:	**92893739.19**
Total Estimated Unduplicated Participants:	**640**
Factor D (Divide total by number of participants):	**145146.47**
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutrition Services	15 min.	327	42.00	30.13	413805.42	
Occupational Therapy Services Total:						206281.64
Occupational Therapy Services	15 min.	116	79.00	22.51	206281.64	
Optometry Total:						40340.16
Exam	Per Item	168	1.00	93.58	15721.44	
Corrective lenses	Per Item	168	1.00	146.54	24618.72	
Physical Therapy Services Total:						291729.60
Physical Therapy Services	15 min.	216	60.00	22.51	291729.60	
Physician Services (provided by a Psychiatrist) Total:						679.20
Physician Services (provided by a Psychiatrist)	30 min.	5	2.00	67.92	679.20	
Psychological Services Total:						303420.00
Psychological Services	15 min.	130	100.00	23.34	303420.00	
Remote Supports Total:						58078.80
Remote Supports	15 min.	9	2920.00	2.21	58078.80	
Respite Daily Total:						4501.20
Out of Home	Per day	3	10.00	129.46	3883.80	
In Home	Per day	2	5.00	61.74	617.40	
Specialized Foster Care also known as Specialized Family Home/Care Total:						130212.18
Specialized Foster Care also known as Specialized Family Home/Care	Per day	6	357.00	60.79	130212.18	
Specialized Medical Supplies and Assistive Technology Total:						1005433.47
Specialized Medical Supplies	Per item	309	2958.00	0.90	822619.80	
Assistive Technology	Per item	103	41.00	43.29	182813.67	

GRAND TOTAL:	92893739.19
Total Estimated Unduplicated Participants:	640
Factor D (Divide total by number of participants):	145146.47
Average Length of Stay on the Waiver:	355

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech Therapy Services Total:						**124362.00**
Speech Therapy Services	15 min.	98	60.00	21.15	**124362.00**	
Transportation Total:						**2110080.00**
Transportation	1 mile	600	5024.00	0.70	**2110080.00**	

GRAND TOTAL:	**92893739.19**
Total Estimated Unduplicated Participants:	**640**
Factor D (Divide total by number of participants):	**145146.47**
Average Length of Stay on the Waiver:	355