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 waiver’s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

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

B. Program Title: ADvantage

C. Waiver Number: OK.0256
   Original Base Waiver Number: OK.0256.

D. Amendment Number: OK.0256.R04.04

E. Proposed Effective Date: [mm/dd/yy] 03/01/15
   Approved Effective Date of Waiver being Amended: 07/01/11

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Updated State Medicaid Agency Representative
Completed HCBS Settings Waiver Transition Plan
Updated eligibility group from 209(b) to SSI Criteria State
Added Taxonomy categories for all waiver services
Added language for Assisted Living services clarifying Final Rule requirements
Added language explaining compliance with Final Rule settings requirements
Updated language to demonstrate compliance with Final Rule provider conflict of interest requirements
Updated language regarding safeguards and seclusion
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):

<table>
<thead>
<tr>
<th>Component of the Approved Waiver</th>
<th>Subsection(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver Application</td>
<td></td>
</tr>
<tr>
<td>Appendix A – Waiver Administration and Operation</td>
<td></td>
</tr>
<tr>
<td>Appendix B – Participant Access and Eligibility</td>
<td>B-4-a-1, B-4-b</td>
</tr>
<tr>
<td>Appendix C – Participant Services</td>
<td>C-1/C-3,C-2,C-5</td>
</tr>
<tr>
<td>Appendix D – Participant Centered Service Planning and Delivery</td>
<td>D-1-b</td>
</tr>
<tr>
<td>Appendix E – Participant Direction of Services</td>
<td></td>
</tr>
<tr>
<td>Appendix F – Participant Rights</td>
<td></td>
</tr>
<tr>
<td>Appendix G – Participant Safeguards</td>
<td>G-2-a, G-2-c</td>
</tr>
<tr>
<td>Appendix H</td>
<td></td>
</tr>
<tr>
<td>Appendix I – Financial Accountability</td>
<td></td>
</tr>
<tr>
<td>Appendix J – Cost-Neutrality Demonstration</td>
<td></td>
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</tbody>
</table>

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: Remove language that refers to $0.00 copayment amount for generic drugs. This will no longer apply to preferred generic drugs.

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):

ADvantage

C. Type of Request: amendment

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

E. Proposed Effective Date of Waiver being Amended: 07/01/11
   Approved Effective Date of Waiver being Amended: 07/01/11

1. Request Information (2 of 3)

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

☐ Hospital
  Select applicable level of care
  ☐ Hospital as defined in 42 CFR §440.10
    If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

☐ Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160
☐ Nursing Facility
  Select applicable level of care
  ☐ Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155
    If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

☐ Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐ Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)
  If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:
  ☐ Not applicable
  ☐ Applicable
    Check the applicable authority or authorities:
    ☐ Services furnished under the provisions of §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 Eligibility for Medicaid and Medicare.

Check if applicable:
- [x] 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.

OKLAHOMA’S ADvantage WAIVER PROGRAM

Under the Medicaid Home and Community-Based Waiver ADvantage Program, the Oklahoma Department of Human Services, Division of Aging Services, offers the following services to eligible adults as an alternative to care in a nursing facility:
- Case Management Services
- Personal Care
- Respite Care
- Adult Day Health Care with Personal Care and Therapy Enhancements
- Environmental Modifications
- Specialized Medical Equipment and Supplies
- Advanced Supportive/Restorative Assistance
- Nursing
- Prescription Drugs
- Home-Delivered Meals
- Therapy Services: Physical, Occupational and Speech & Language
- Hospice Care
- Personal Emergency Response System (PERS)
- Institution Transition Services
- Consumer-Directed Personal Assistance Services and Supports (CD-PASS)
- Assisted Living Services.
- Skilled Nursing.

The goal of this program is to provide services which allow Medicaid eligible persons who need nursing facility level of care to remain at home or in the residential setting of their choosing while receiving the necessary care. The ADvantage Program is a home and community-based alternative to placement in a nursing facility to receive Medicaid-funded assistance for care. The program uses agency and individual self-direction methods of service delivery. The ADvantage waiver incorporates self-direction opportunities as a service delivery mechanism in certain geographic locations. These opportunities will be expanded statewide in this 5 year waiver renewal cycle. The program is cost effective, in that Medicaid expenditures for services under The ADvantage Program must be less than the Medicaid-funded institutional services would have been had the individuals been served in a nursing facility.

The ADvantage home and community-based waiver program is a State of Oklahoma Medicaid program managed by the Department of Human Services, Aging Services Division. As a Medicaid program, federal and state guidelines, rules, regulations and law govern the operation of the program. At the federal level, the Centers for Medicare and Medicaid Services (CMS) is the authoritative body for the administration of Medicaid programs. At the state level, authority for the operation of Medicaid programs rests with the Oklahoma Health Care Authority (OHCA), the State Medicaid Agency. Under an interagency agreement with the Oklahoma Health Care Authority, the Aging Services Division of OKDHS administers the ADvantage waiver program.
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 statewide 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:

In waiver year one, CD-PASS services will be furnished only to individuals who reside in the counties of Tulsa, Creek, Rogers, Wagoner, or Pittsburg or who reside in one of the following zip codes within Osage County: 74126, 74127, 74106, or 74063.

In waiver year two, CD-PASS service availability will be extended to the counties of Oklahoma, Canadian and Cleveland.

By the end of waiver year five CD-PASS services will be available statewide.

Participants who live in CD-PASS service areas have the choice to receive waiver services through any ADvantage offered service delivery method.

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 6-1 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 development process:

- On January 9, 2013, OHCA met with representatives of American Indian Nations, Indian Health Services, and the Tribal and Urban Indian Health Clinics located in Oklahoma (the ITU) Council to inform them about the proposed ADvantage amendment concerning out of state providers for the provision of home delivered meals. No questions or comments concerning home delivered meals were received at this meeting.

- On October 4, 2013, DHS Aging Services emailed all provider agencies a bulletin regarding the proposed home delivered meal amendment. One question was received, regarding time and location of the public input meeting.

- On October 13, 2013 a public meeting notice was placed in the following papers: Ardmore Ardmoreite, Claremore Daily Progress, McAlester News, Enid News and Eagle, Lawton Constitution, and The Daily Oklahoman.

72 attended the public meeting held November 4, 2013 in Oklahoma City at the Moore Norman Technology Center. The following questions, with the answers provided, are noted below:

1) Can providers have a Title IIC contract from other states? Yes, however they still must comply with the same contractual documents required by in-state providers.

2) How will the meals be delivered and must they be signed for? Out of state meals will be delivered through UPS and Federal Express. Yes, members must still sign for meals upon delivery.

3) Will out of state providers choose the county they want to serve? No, their service area will be statewide.

- On November 14, 2013 the proposed waiver amendment was posted at the OHCA website allowing thirty days for public comment. No comments regarding the amendment were received.

- On November 21, 2013 the proposed waiver amendment was presented to the OHCA Medical Advisory Committee for informational purposes only. No comments or questions were received.

- On May 6th, 2014 a Tribal Consultation meeting was held at the OHCA. The meeting included an explanation of the Final Rule requirements. No comments or questions were received from any of the Tribal members or associates.

- On June 11th, 2014 the Final Rule requirements were presented to the Medical Advisory Committee for informational purposes only.
On June 10th, July 2nd, July 23 and August 5th, provider notifications were posted on the DHS/ADvantage website informing providers of the Final Rule requirements.

On June 25, 2014 DHS staff met with ADvantage providers to discuss the Final Rule at the OG&E Technology Center in Oklahoma City. There were approximately 100 attendees. The informational session included an overview of the CMS Rules and the applicability to the ADvantage and SPPC programs.

On July 1, and August 5th, letters were mailed out to all ADvantage members informing them of the Final Rule requirements that could potentially effect them and notifying them that their case manager will contact them if changes are needed.

On July 3rd, 2014 the proposed Final Rule waiver amendments were posted for 30 days on the OHCA website for public comment. One comment was received on July 7, 2014 seeking clarification on the the Final Rule regarding case managers who have a financial interest in an Adult Day Health facility. A reply was sent to the individual explaining that the case manager will not be able to provide case management services to individuals receiving services at the Adult Day Health center where the case manager has a financial interest. It was further explained that if individuals do receive case management services from that individual they will have to access services from a different Adult Day Health facility than the facility where the case manager has a financial interest. The individual responded back thanking us for the clarification.

On July 24, 2014 the OHCA received a written inquiry from Life Senior Services regarding application of the conflict free case management portion of the Final rule to their Adult Day Health facility. On August 1st, the OHCA sent out an written response explaining how the provisions of the conflict free case management provisions apply to the operation of their facility. No further communication has been received from Life Senior Services in response to our letter.

**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.


7. **Contact Person(s)**

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

   **Last Name:**
   Antwine

   **First Name:**
   Lekena

   **Title:**
   Waiver Administration Coordinator

   **Agency:**
   Oklahoma Health Care Authority

   **Address:**
   4345 N. Lincoln Boulevard
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: Splinter, M.D.
First Name: Garth L.
Title: State Medicaid Director
Agency: Oklahoma Health Care Authority
Address: 4345 N. Lincoln Blvd.
Address 2: 
City: Oklahoma City
State: Oklahoma
Zip: 73105
Phone: (405) 522-7365 Ext: TTY
Fax: (405) 530-3450
E-mail: Garth.Splinter@okhca.org

Attachments

Attachment #1: Transition Plan

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.

Oklahoma Transition Plan for HCBS Setting Compliance for the ADvantage Waiver (256)

Purpose:
The purpose of this Transition Plan is to ensure the individuals receiving Home and Community-Based Services (HCBS) are integrated in and have access to supports in the community, including opportunities to seek employment, work in competitive integrated settings, engage in community life, and control personal resources. Overall, the Transition Plan provides assurance that the individuals receiving HCBS have the same degree of access as individuals not receiving Medicaid HCBS. This Transition Plan outlines the proposed process that Oklahoma will be utilizing to ensure implementation of the new HCBS requirements. Stakeholders are being asked to provide public input and comment in order to allow Oklahoma to develop a comprehensive assessment plan.

The transition plan will include:
• A 30-day public comment period of the draft transition plan;
• A response summary of public comments received;
• A plan to review applicable state standards, rules, regulations and policies;
• A plan for assessing HCBS settings;
• A time frame for a summary of how each setting meets or does not meet the federal HCBS setting requirements;
• A plan for ensuring the health and safety of members who reside in locations that need to meet corrective action requirements for the setting to come into compliance during the state’s specified transition time.

Oklahoma’s Assessment Plan for HCBS Requirements

Phase 1-
Start Date: January 2015
End Date: March 2015
Analysis Completion Date: April 2015

The Oklahoma Health Care Authority (OHCA) will work with various providers, members, family, guardians, and other stakeholders involved in the waiver programs to gather the information needed to evaluate Oklahoma’s current compliance with the HCBS regulations. This process will be conducted utilizing currently available data, through surveys, site visits, interviews and stakeholders.

Oklahoma has chosen to utilize a transition plan assessments, surveys, and site visits to begin the process by which to evaluate compliance. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice and health and safety. This information will be used as a starting point to allow Oklahoma and its stakeholders to highlight the areas of concern. As available, the transition plan assessments, surveys, and site visits will be analyzed by the type of residence in order to identify noncompliance within HCBS settings. The data obtained will be derived from a random sample of members and providers across Oklahoma.

Phase 2-
Start Date: April 2015
End Date: June 2015
Analysis Date: July 2015

Information obtained from the analysis of the transition plan assessments, surveys, and site visits will delineate the areas that Oklahoma may show noncompliance with HCBS requirements. Those areas of noncompliance will be targeted utilizing an Assessment Tool for Community Settings. Upon completion of the assessment tool, responses will be validated. The assessment tool will be created for utilization across all HCBS settings where applicable. In addition, targeted provider surveys will be utilized to provide a more detailed account of compliance/noncompliance in terms of HCBS settings.
In conjunction with the assessment tool and provider surveys, an assessment of Oklahoma policies and procedures will be completed to identify compliance/noncompliance with the new federal HCBS rules. More specifically, a systematic review of:

- Provider Enrollment and Re-Approval Requirements
- Current trainings to integrate the new HCBS requirement

Phase 3-
Start Date: July 2015
End Date: October 2015

Information obtained from the analysis of internal programmatic data and transition plan assessments, surveys, and site visits will be utilized to identify areas of compliance and noncompliance. The data and the identified areas of noncompliance will be used to gather further qualitative feedback from providers, members, and their families. Input will be gathered through a variety of means that include but are not limited to:

- Member focused groups and surveys
- Focus groups with service provider and DHS and/or OHCA staff
- Advocacy groups
- Long-Term Care Quality Initiatives Council and Living Choice Advisory Committee

Phase 4-
Start Date: March 2015
End Date: July 2015

OHCA will develop an inventory and description of HCBS settings types and summarize how each setting meets or does not meet the federal HCBS requirements. Review and analysis will be conducted from the following sources:

- Provider Surveys
- Family/Participant interviews, site visits, etc.
- Stakeholder input
- Internal programmatic data

Phase 5-
Start Date: July 2015
End Date: September 2015

OHCA will:

- Compile a summary of areas of compliance and noncompliance
- Provide periodic monitoring of HCBS settings (ongoing)
- Complete additional review, if warranted
- Develop corrective action strategy and a formal transition plan to ensure Oklahoma meets the new HCBS requirements
- Identify current policies, trainings, and procedures that need to be modified to meet the HCBS standards

Below is a summary of the assessment plan activities that Oklahoma will utilize to develop a comprehensive transition plan upon approval of CMS:

**HCBS Rule**
**REQUIREMENT:** Is integrated in and supports access to the greater community

**Assessment Activity**
Analyze data from responses gathered through member and provider surveys and transition plan assessments in the following question areas:

- Individual interacts with neighbors
- Extent to which people do certain activities in the community
- Individual has a paid job in the community

Start Date End Date
1/2015 3/2015
HCBS Rule
REQUIREMENT: Control personal resources

Assessment Activity
Analyze data from responses gathered through member and provider surveys and transition plan assessments in the following question areas:
• Individual can decide how to spend his/her own money
• Individual can access personal funds

Start Date End Date
1/2015 3/2015

HCBS Rule
REQUIREMENT: Allows full access to the greater community/ Engaged in community life

Assessment Activity
Analyze data from responses gathered through member and provider surveys and transition plan assessments in the following question areas:
• Individuals have a variety of recreation/leisure opportunities
• Individual interacts with neighbors

Start Date End Date
1/2015 3/2015

HCBS Rule
REQUIREMENT: Setting is chosen among setting options including non-disability specific settings and options for a private unit in a residential settings.

Assessment Activity
Analyze data from responses gathered through member and provider surveys and transition plan assessments in the following question areas:
• Setting was selected by the individual
• Choose or had input in where they go during the day
• Choose Free Time

Start Date End Date
1/2015 3/2015

HCBS Rule
REQUIREMENT: Ensures right to privacy, dignity and respect and freedom from coercion and restraint

Assessment Activity
Analyze data from responses gathered through member and provider surveys and transition plan assessments in the following question areas:
• Staff interacts positively and with respect towards everyone
• Individual has privacy; mail/email is not read without permission, etc.

Start Date End Date
1/2015 3/2015

HCBS Rule
REQUIREMENT: Setting is physically accessible to the individual

Assessment Activity
Analyze data from responses gathered through member and provider surveys and transition plan assessments in the following question area:
• Home has adaptations and is accessible

Start Date End Date
1/2015 3/2015
HCBS Rule
REQUIREMENT: Privacy in their unit including entrances lockable by the individual

Assessment Activity
Analyze data from responses gathered through member and provider surveys and transition plan assessments in the following question areas:
• If others announce themselves before entering home
• If others announce themselves before entering bedroom
• If individual has enough privacy

Start Date End Date
1/2015 3/2015

HCBS Rule
REQUIREMENT: Visitors at any time

Assessment Activity
Analyze data from responses gathered through member and provider surveys and transition plan assessments in the following question areas:
• Individuals have control over their own lives
• Whether individual can be alone with visitors or if there are some rules/restrictions
• Relationships are encouraged and supported

Start Date End Date
1/2015 3/2015

HCBS Rule
REQUIREMENT: Individuals sharing units have a choice of roommates in that setting

Assessment Activity
Analyze data from responses gathered through member and provider surveys and transition plan assessments in the following question areas:
• Choose or had some input in choosing their roommates
• If individuals choose to live alone, or choose people they live with

Start Date End Date
1/2015 3/2015

HCBS Rule
REQUIREMENT: Freedom to furnish and decorate the individuals unit

Assessment Activity
Analyze data from responses gathered through member and provider surveys and transition plan assessments in the following question area:
• The house reflects the personalities of the individual

Start Date End Date
1/2015 3/2015

HCBS Rule
REQUIREMENT: Optimizes autonomy and independence in making life choices

Assessment Activity
Analyze data from responses gathered through member and provider surveys and transition plan assessments in the following question areas:
• Individuals feel empowered by the decisions they make
• Individuals make as many daily choices as they can
• Individuals have control over their lives
• Individuals are included in running the household

Start Date End Date
1/2015 3/2015

HCBS Rule
REQUIREMENT: Facilitates individual choice of services and supports and who provides them

Assessment Activity
Analyze data from responses gathered through member and provider surveys and transition plan assessments in the following question areas:

• Individuals are given a choice among qualified providers and the choice has been documented properly
• Individual chose their home, job, day program or activity staff
• Individual receives services they need
• Individual assisted in the development of the service plan

Start Date End Date
1/2015 3/2015

HCBS Rule
REQUIREMENT: A lease of legally enforceable agreement to protect from eviction

Assessment Activity
Analyze data from responses gathered through member and provider surveys and transition plan assessments in the following question areas:

• Individuals or their informal/natural supporters hold a lease or written residency agreement for the setting
• Written agreement includes language that provides protection against protection and allows appeals of eviction notices

Start Date End Date
1/2015 3/2015

HCBS Rule
REQUIREMENT: Ensures the individual receives services in the community with the same degree of access as individuals not receiving Medicaid HCBS

Assessment Activity
Analyze data from responses gathered through member and provider surveys and transition plan assessments in the following question areas:

• Individual lives in or receives HCBS services in an area of the setting which is not separate from individuals not receiving Medicaid services

Start Date End Date
1/2015 3/2015

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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 (OKDHS)

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 Medicaid Agency monitors that the operating agency performs assigned waiver operational and administrative functions in accordance with the Interagency Agreement between OHCA and OKDHS. The operational and administrative functions specifically delegated, in whole or in part, to OKDHS through the Interagency Agreement are:

• Member enrollment;
• Waiver operates within approved cap limits;
• Assuring that waiver expenditures are managed against approved levels;
• Performing level of care evaluations;
• Annual, and as needed other, reviews of member service plans;
• Transmittal of service plan data to establish prior authorization of services;
• Implementation of utilization management;
• Recruitment of qualified providers;
• Assistance with promulgation and implementation/distribution of rules, policies and information governing the waiver; and
• The provision of training, technical assistance, quality assurance and quality improvement activities.

The Interagency Agreement is reviewed and updated at least annually.
The OHCA (Medicaid agency) utilizes several processes to assess the OKDHS (Operating agency) performance. The frequency of assessment of function depends upon the individual process but is usually on a monthly or quarterly basis. Below the different processes used to assess Operating agency performance are described.

Enrollment – The Medicaid Agency monitors the OKDHS processes and performance in Medicaid applicant enrollment in compliance with the Interagency Agreement. The OHCA monitors the enrollment process utilizing two committees which monitor enrollment activities and any problems related to enrollment. The Steering Committee meets monthly and includes executive staff from the OHCA and DHS. This committee makes decisions related to eligibility and programs issues and provides direction for the CQIP (Continuous Quality Improvement Process) team. The CQIP team, which includes representatives from DHS and OHCA, provides technical assistance and investigates for the Steering Committee and works on eligibility problems which do not require attention from executive staff. The CQIP team develops and regularly reviews reports which reflect the timeliness and accuracy of the enrollment process and the efficiency of data exchanges between OHCA and DHS. The CQIP team also conducts periodic “listening Sessions with DHS field staff. Data gathered from the sessions is used to improve, clarify and streamline the enrollment process and eliminate errors.

The Medicaid Agency monitors the Operating agency performance on all other assigned waiver operational and administrative functions in accordance with waiver requirements through review of periodic (monthly or quarterly) reports and participation in quarterly meetings of the Long Term Service and Supports Council (LTSSC) and the Quality Management Strategies Council (QMSC). The OHCA Waiver Administration Director responsible for waiver administration receives a copy of all waiver management reports and takes a lead role in both the Long Term Service and Supports Council (LTSSC) and the Quality Management Strategies Council (QMSC).

The performance is monitored by the OHCA Waiver Administration Director based on performance standards.

OKDHS (the Operating agency) is responsible for providing, at a minimum, quarterly reports of activities furnished in support of waiver members. These reports are analyzed by the Senior Program Manager. On a quarterly basis, the Waiver Administration Director assesses performance and reports findings to the Long Term Care Quality Initiatives Council (LTCQIC). Although contractor performance is monitored on an ongoing basis by the Waiver Administration Director, formal performance assessment of the Operating Agency occurs at least once each year as part of the annual readiness review and operational compliance review of the Interagency Agreement.

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:

  A private entity has been contracted through an RFP process to provide Fiscal Management Services (FMS) on behalf of OKDHS for participants receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS). The FMS entity is responsible for all Fiscal Management Services described under scope of services in Appendix E including:

  - Collect and process timesheets of support workers
  - Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
  - Maintain a separate account for each participant’s participant-directed budget
  - Track and report participant funds, disbursements and the balance of participant funds
  - Process and pay invoices for goods and services approved in the service plan
  - Provide participant with periodic reports of expenditures and the status of the participant-directed budget
  - Keep on file the worker Medicaid provider agreements
  - Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency, and
  - Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
A private entity has been contracted through an RFP process to provide an interactive voice response authentication (IVRA) system (OK AuthentiCare) to be used by ADvantage service providers of Home Care and Case Management services statewide. The system is a time and attendance verification and tracking system supported through specialized telephony and web-based software. The system allows real-time tracking of service delivery with alerts for missed or late visits. The system provides numerous management reports for providers and for the state to review service utilization.

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:

The Long Term Care Authority (LTCA) of Enid, a local public trust authority, assists in enrollment, certification as “qualified” and orientation of new ADvantage Program providers. In addition, the LTCA of Enid assists in recertification of existing providers as meeting standards as “qualified” ADvantage service providers.

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:

Oklahoma Department of Human Services

Appendix A: Waiver Administration and Operation

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

The OKDHS Contract Manager reviews quarterly reports of LTCA of Enid performance in meeting contract responsibilities in accordance with performance standards and produces an annual assessment of contract performance. OKDHS shares monitoring reports with the OHCA and the OHCA has input into meetings for which contractor has a major responsibility. OKDHS and OHCA regularly review LTCA of Enid performance of contracted responsibilities during quarterly QMSC and LTSSC meetings in which the Director of LTCA of Enid
participates.

The OKDHS Contract Manager reviews monthly reports that track and summarize the performance of PPL in meeting contract performance standards for CD-PASS member customer support. In addition, OKDHS and OHCA staffs participate in monthly teleconference calls with PPL staff to review these management reports and review issues related to contracted responsibilities. OKDHS staff review on an ongoing basis individual and aggregated reports that track CD-PASS member budget disbursements, OKDHS and OHCA regularly review PPL performance of contracted responsibilities during quarterly QMSC and LTSSC meetings. Annually the OKDHS Contract Manager submits a summary Professional Services Evaluation report on PPL performance to the OKDHS Contracts & Purchasing Unit.

OKDHS and OHCA staff participate in monthly teleconference calls with FD staff to review issues related to contracted responsibilities in implementing the AuthentiCare system including issues raised by providers in using the system. OKDHS staff review on an ongoing basis AuthentiCare reports aggregated by provider that track service delivery including missed or late visits, claims payments, use of unauthorized phone for tracking service delivery and voice authentication failures. OKDHS and OHCA regularly review FD performance of contracted responsibilities during quarterly QMSC and LTSSC meetings. Annually the OKDHS Contract Manager submits a summary Professional Services Evaluation report on FD performance to the OKDHS Contracts & Purchasing Unit.

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.

<table>
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<tr>
<th>Function</th>
<th>Medicaid Agency</th>
<th>Other State Operating Agency</th>
<th>Contracted Entity</th>
<th>Local Non-State Entity</th>
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<td>Waiver enrollment managed against approved limits</td>
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<td>Waiver expenditures managed against approved levels</td>
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<td>Level of care evaluation</td>
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<td>Prior authorization of waiver services</td>
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<td>Utilization management</td>
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<td>Qualified provider enrollment</td>
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<td>Establishment of a statewide rate methodology</td>
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<td>Rules, policies, procedures and information development governing the waiver program</td>
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<tr>
<td>Quality assurance and quality improvement activities</td>
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Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

https://wms-mmdl.cdsvdc.com/WMS/faces/protected/35/print/PrintSelector.jsp
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 percentage of members enrolled by OKDHS in the waiver according to policy as outlined in the agreement with the Medicaid agency. Numerator: Number of members enrolled in the waiver by OKDHS according to policy and interagency agreement Denominator: Total number of members enrolled in waiver

Data Source (Select one):
Other

If ‘Other’ is selected, specify:

MMIS, ELDERS and WMIS Information Management Systems

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<tr>
<th>Responsible Party for data collection/generation (check each that applies):</th>
<th>Frequency of data collection/generation (check each that applies):</th>
<th>Sampling Approach (check each that applies):</th>
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<td>☑ State Medicaid Agency</td>
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<td>☑ 100% Review</td>
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<td>☑ Operating Agency</td>
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| ☐ Sub-State Entity | ☑ Quarterly | ☑ Representative Sample  
Confidence Interval = 95% |
| ☐ Other  
Specify: | ☑ Annually | ☐ Stratified  
Describe Group: |
| ☐ Continuously and Ongoing | ☐ Other  
Specify: |
Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):

- [ ] State Medicaid Agency
- [ ] Operating Agency
- [ ] Sub-State Entity
- [ ] Other
  Specify:

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

- [ ] Weekly
- [ ] Monthly
- [ ] Quarterly
- [ ] Annually
- [ ] Continuously and Ongoing
- [ ] Other
  Specify:

Performance Measure:
Total number and percentage of members enrolled by OKDHS that are within approved limits of the waiver. Numerator: Total unduplicated number of enrolled that are within participant limits of the waiver. Denominator: Total number of enrolled members.

Data Source (Select one):

Other
If 'Other' is selected, specify:

ADvantage Waiver Management Information System (WMIS)

Responsible Party for data collection/generation (check each that applies):

- [ ] State Medicaid Agency
- [ ] Operating Agency
- [ ] Sub-State Entity

Frequency of data collection/generation (check each that applies):

- [ ] Weekly
- [ ] Monthly
- [ ] Quarterly

Sampling Approach (check each that applies):

- [ ] 100% Review
- [ ] Less than 100% Review
- [ ] Representative Sample
  Confidence Interval =
Data Aggregation and Analysis:

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Performance Measure:
Number and percentage of member service plans that do not exceed approved waiver expenditure levels according to OKDHS and Medicaid Agency interagency agreement. Numerator: Number of member service plans that do not exceed approved waiver expenditure levels Denominator: Total number of member service plans

Data Source (Select one):
Other
If ‘Other’ is selected, specify: WMIS

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### Performance Measure:
Number and percentage of CD-PASS members whose utilization of CD-PASS services do not exceed approved service plan CD-PASS unit limits. Numerator: Number of CD-PASS members whose utilization of CD-PASS services do not exceed approved service plan CD-PASS unit limits. Denominator: Total number of CD-PASS member service plans

### Data Source (Select one):
Other
If ‘Other’ is selected, specify:

### FMS provider reports

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<td>Number and percentage of initial LOC determinations made by OKDHS within the timeframe specified in Medicaid agency policy. Numerator: Number of initial LOC determinations made within the timeframe specified in policy Denominator: Total number of initial LOC determinations</td>
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Data Source (Select one): Other
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### Performance Measure:

Number and percent of service plan waiver services that receive MMIS prior authorization as specified in the agreement with the Medicaid agency. Numerator: Number of member service plan services that receive MMIS prior authorization. Denominator: Number of member waiver services.

### Data Source (Select one):

**Other**  
If ‘Other’ is selected, specify: **WMIS**

### Responsible Party for data collection/generation (check each that applies):

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### Performance Measure:
Number and percentage of service plans on new members completed by OKDHS in the timeframe specified in Medicaid agency policy. Numerator: Number of service plans on new members completed by OKDHS in the timeframe specified in policy Denominator: Number of service plans on new members completed

### Data Source (Select one):
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If ‘Other’ is selected, specify:
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Performance Measure:
Except for Pharmacy and Medical Equipment and Supply providers, Number and percentage of providers certified as qualified by OKDHS prior to enrollment in accord with the OKDHS interagency agreement with the Medicaid Agency. Numerator: Number of providers certified as qualified by OKDHS prior to enrollment Denominator: Number of providers enrolled

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

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Performance Measure:
Number and Percent of waiver related policies developed by OKDHS that received approval by the Medicaid agency prior to implementation. Numerator: Number of waiver policies or policy revisions developed by OKDHS that received approval by the Medicaid agency prior to implementation Denominator: Number of waiver policies or policy revisions developed by OKDHS that were implemented

Data Source (Select one):
Program logs
If 'Other' is selected, specify:

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**Performance Measure:**

Number and percentage of provider audits conducted by OKDHS in accordance with the interagency agreement with the Medicaid agency. Numerator: Number of provider
audits conducted by OKDHS according to policy or the interagency agreement
Denominator: Number of provider audits conducted by OKDHS

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### Performance Measure:
Number and Percent of reports performed timely, complete and in the correct format in accordance with contract with the state Numerator: Number of reports performed timely, complete and in the correct format in accordance with contract. Denominator: Total Number of reports required

### Data Source (Select one):
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Performance Measure:
Number and Percent of member budgets administered by FMS in accordance with state requirements. Numerator: Number of Member budgets administered by FMS that followed requirements Denominator: Total number of CD-PASS members

Data Source (Select one):
Other
If 'Other' is selected, specify:
FMS Performance monitoring

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Specify:

- Continuously and Ongoing
- Other

### Performance Measure:
Number and Percent of Providers enrolled by the FMS that met provider qualifications prior to performing services for members choosing self-direction. Numerator: Number of CD-PASS Providers enrolled by the FMS that met qualifications prior to performing service. Denominator: Total Individual providers enrolled by the FMS to perform services for members choosing self-direction

### Data Source (Select one):
- Other

If 'Other' is selected, specify:

#### FMS Performance monitoring

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Describe Group:
Continuously and Ongoing

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Performance Measure:
Number and Percent of reports made available by IVRA provider that are performed timely, complete and in the correct format as specified in the agreement with the state
Numerator: Number of reports made available by IVRA provider that are performed timely, complete and in the correct format in accordance with agreement
Denominator: Total Number of reports required

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

IVRA Provider Monitoring

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- **Describe Group:**
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### Performance Measure:

Number and Percent of days IVRA system meets requirements of availability for use in accordance with state agreement

- **Numerator:** Number days that availability for use met requirements
- **Denominator:** Total Number of days in reporting period

### Data Source (Select one):

- Other
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  - IVRA Provider Performance monitoring
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Number and Percent of provider enrollment activities performed by LTCA of Enid in accordance with state agreement

Numerator: Number of reports provider enrollment activities performed in accordance with agreement
Denominator: Total Number provider enrollment activities covered by agreement with LTCA of Enid

Data Source (Select one):
Other
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LTCA of Enid performance monitoring

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

**b. Methods for Remediation/Fixing Individual Problems**

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

OHCA and OKDHS 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. The OHCA dedicated waiver staff will maintain administrative authority through the use of an electronic database designed for storing information received related to problems identified and resolutions of these matters. The OHCA Director of Waiver Administration and Development will be directly responsible for mediating any individual problems pertaining to administrative authority. The Director of Waiver Administration and Development will work with the designated OKDHS Point of Contact to resolve any problems in a timely manner.

Individual problems may be discovered during monitoring activities by the State or by any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring and frequency are described in each performance measure of this appendix.

The options for remediation are listed below. If as part of remediation, a corrective action plan is required, the plan will detail the steps to be taken to prevent future performance failures along with the timeframe, not to exceed 30 days, for implementation of the corrective actions. Any performance failures, or remediation corrective actions, that may result in a loss of eligibility or reduction of services for one or more individual members will be referred to the EOCC for appropriate follow-up to safeguard the health and safety of members affected.

**Member Enrollment/LOC/Waiver Policies**

Medicaid Agency staff monitor that all policies have prior OHCA approval prior to implementation and that ADVantage LOC and enrollments have been completed in accordance with required time-frames and other policy requirements and that enrollments are within the limits of the approved waiver. If any instances are found in which waiver policies have been implemented prior to Medicaid Agency approval, LOC was not performed within policy timeframe, enrollment was not completed timely, or enrollments exceed waiver limits, OKDHS is contacted directly for resolution and, if deemed necessary, OKDHS will be required to submit, within five working days of request, a corrective action plan to the Director of Waiver Administration and Development.

**Member Service Plans**

If any instances are found in which claims for ADVantage services have been paid without an existing prior authorization, or member service plans have not been completed timely or that service plans have been approved that exceed the waiver expenditure levels, or if CD-PASS members utilize more units than have been approved on their service plan, OKDHS is contacted directly for resolution and, if deemed necessary,
OKDHS will be required to submit, within five working days of request, a corrective action plan to the Director of Waiver Administration and Development.

Qualified Providers

If any instances are found in which providers have been certified prior to enrollment or provider audits have not been conducted in accordance with agreement with the Medicaid agency, OKDHS is contacted directly for resolution and, if deemed necessary, OKDHS will be required to submit, within five working days of request, a corrective action plan to the Director of Waiver Administration and Development.

Remediation of non-State entity contracted functions:

Financial Management Services Fiscal Agent

If any instances are found in which the Fiscal Agent has not completed reports according with agreement, or administered member budgets in accordance with requirements, or enrolled a provider after they had provided services to a member or that had not met provider qualifications, the FMS contracted agent is contacted directly for resolution and, if deemed necessary, the FMS will be required to submit, within five working days of request, a corrective action plan to the OKDHS Contract Manager who will share the plan with the Director of Waiver Administration and Development. In addition, liquidated damages may be assessed against the FMS for certain performance measure failures if in violation of contract requirements.

Interactive Voice Response Authentication Contractor

If any instances are found in which the IVRA provider has not made available reports according with agreement, or adequately supported the IVRA system to be available for use in accordance with the state agreement, the IVRA provider is contacted directly for resolution and, if deemed necessary, the IVRA provider will be required to submit, within five working days of request, a corrective action plan to the OKDHS Contract Manager who will share the plan with the Director of Waiver Administration and Development. In addition, liquidated damages may be assessed against the IVRA provider for certain performance measure failures if in violation of contract requirements.

LTCA of Enid

The OKDHS Contract Manager reviews quarterly reports of LTCA of Enid performance in meeting contract responsibilities in accordance with performance standards and produces an annual assessment of contract performance. OKDHS shares monitoring reports with the OHCA and the OHCA has input into meetings for which contractor has a major responsibility. If any instances are found in which the LTCA of Enid has not performed enrollment activities in accordance with state agreement, the LTCA of Enid will be required to submit, within five working days of request, a corrective action plan to the OKDHS Contract Manager who will share the plan with the Director of Waiver Administration and Development.

ii. Remediation Data Aggregation

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

<table>
<thead>
<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️ State Medicaid Agency</td>
<td>☐ Weekly</td>
</tr>
<tr>
<td>✗ Operating Agency</td>
<td>✔️ Monthly</td>
</tr>
<tr>
<td>☐ Sub-State Entity</td>
<td>✗ Quarterly</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☒ Annually</td>
</tr>
<tr>
<td>Specify:</td>
<td>☒ Continuously and Ongoing</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☐ Other</td>
</tr>
<tr>
<td>Specify:</td>
<td></td>
</tr>
</tbody>
</table>

https://wms-mmdl.cdsvdc.com/WMS/faces/protected/35/print/PrintSelector.jsp
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:

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Included</th>
<th>Target SubGroup</th>
<th>Minimum Age</th>
<th>Maximum Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged or Disabled, or Both - General</td>
<td>✓</td>
<td>Aged</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Aged or Disabled, or Both - General</td>
<td>✓</td>
<td>Disabled (Physical)</td>
<td>21</td>
<td>64</td>
</tr>
<tr>
<td>Aged or Disabled, or Both - General</td>
<td>✓</td>
<td>Disabled (Other)</td>
<td>21</td>
<td>64</td>
</tr>
<tr>
<td>Aged or Disabled, or Both - Specific Recognized Subgroups</td>
<td></td>
<td>Brain Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged or Disabled, or Both - Specific Recognized Subgroups</td>
<td></td>
<td>HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged or Disabled, or Both - Specific Recognized Subgroups</td>
<td></td>
<td>Medically Fragile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aged or Disabled, or Both - Specific Recognized Subgroups</td>
<td></td>
<td>Technology Dependent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intellectual Disability or Developmental Disability, or Both</td>
<td>✓</td>
<td>Autism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intellectual Disability or Developmental Disability, or Both</td>
<td></td>
<td>Developmental Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intellectual Disability or Developmental Disability, or Both</td>
<td></td>
<td>Intellectual Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td></td>
<td>Mental Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness</td>
<td></td>
<td>Serious Emotional Disturbance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Persons with developmental disability without cognitive impairment related to the developmental disability
**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (select one):

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

**Specify:**

When members that are disabled and younger than age 65 reach age 65 they are transitioned to the categorically eligible Aged subgroup. These members continue receiving ADvantage services as long as they continue to meet financial and medical eligibility criteria.

---

**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.
  Specify percent: [ ]

- [ ] Other:
  Specify:
  [ ]

Appendix B: Participant Access and Eligibility

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

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

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 100% of the institutional average Medicaid cost for that individual.

The individual cost limit is established each year for Nursing Facility (NF) care and corresponding costs necessary to meet needs under NF care. For each upcoming waiver year, an individual cost limit criterion is set for NF care. The NF cost limit is set based upon historical Medicaid costs for the previous four (4) years, deriving the per diem cost in each of those years and projecting by linear regression the per diem cost for the up-coming year.

In accordance with State Medicaid Agency protocols, as part of the AA evaluation of each service plan, the total projected annual cost of the plan is reviewed in comparison with the cost limit. If the plan estimated cost is less than 100% of the cost limit, the plan is judged to meet the cost limit criterion and the individual is deemed to meet program eligibility and is allowed to receive (or continue to receive) waiver services. If the estimated plan cost is more than 100% of the cost limit, the individual is denied access (or continued access) to waiver services.

The member is informed by the OKDHS staff and by the Case Manager of the member’s right to receive a fair hearing regarding any decision with potentially adverse impact on the member including choice of service setting (institution or waiver services), choice of provider or of service, or denial, reduction, suspension or termination of services. Appeals regarding services are directed to the OHCA.

When action is taken on a member’s case, the member is advised in writing by a computer-generated notice of the action, the reason for the action, and rights to appeal. Copies of the notices are kept in the CMS-certified MMIS. The member is informed that a request for a fair hearing regarding eligibility must be submitted in writing to the Legal Division of OHCA, P.O. Drawer 18497, Oklahoma City, OK 73154-0497. The applicant is also advised of the right to legal counsel at the hearing by either a private attorney or free legal help. The written notice includes information about how to access free legal help, where and how to file an appeal, and the time frame in which an appeal must be filed. The Request for a Fair Hearing explains that the member will continue to receive services if a hearing is requested until after a decision is made.
The member also receives written information about the right to request a Fair Hearing and the steps in the process regarding appeals with respect to services. The member is to use the LD-1 form to file a request. The LD-1 form is to be mailed to:
Oklahoma Health Care Authority
Grievance Docket Clerk
Legal Division
P.O. Drawer 18497
Oklahoma City, Oklahoma 73154-0497
OHCA Fax Number is (405) 530-3455
OHCA Docket Clerk Telephone Number is (405) 522-7217

**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:

If 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 would exceed the cost limit in order to assure the participant’s health and welfare, an increase in frequency of waiver service or number of waiver services may be approved for a temporary period, not to exceed 60 days, during which access to appropriate care is arranged. To the extent that waiver services can be utilized within the 60-day period and the service plan not exceed the cost limit, waiver services will be utilized. If the cost of continuing a service plan can not be accomplished within the waiver cost limits, the member will be disenrolled from the waiver on a date prior to the date on which estimated service costs under the waiver would exceed the cost limit. If the individual has been disenrolled from the waiver and still requires services to meet needs within the service transition or appeal rights period, a service plan with required services will be authorized as “State Only” and providers of services will be reimbursed with State funds.

The member is informed in writing by OKDHS that needed services are being denied for the time period requested because authorization would exceed the cost limit for the waiver. If services that exceed the cost limit are required in order to safeguard member health and welfare until transition is accomplished, the member is advised in writing by OKDHS of the decision to authorize services for a time-limited period, not to exceed 60 days. The member’s eligibility for waiver services is extended until transition to an alternate care program is accomplished or for 60 days from the start of the over-cost period for the plan, whichever is less days unless the period for required provision of services is extended awaiting appeal hearing decision.

 Specify:

The member is informed by the OKDHS staff and by the Case Manager of the member’s right to receive a fair hearing regarding any decision with potentially adverse impact on the member including choice of service setting (institution or waiver services), choice of provider or of service, or denial, reduction, suspension or termination of services. Appeals regarding services are directed to the OHCA.

When action is taken on a member’s case, the member is advised in writing by a computer-generated notice of the action, the reason for the action, and rights to appeal. Copies of the notices are kept in the CMS-certified MMIS. The member is informed that a request for a fair hearing regarding eligibility must be submitted in writing to the Legal Division of OHCA, P.O. Drawer 18497, Oklahoma City, OK 73154-0497. The applicant is also advised of the right to legal counsel at the hearing by either a private attorney or free legal help. The written notice includes information about how to access free legal help, where and how to file an appeal, and the time frame in which an appeal must be filed. The Request for a Fair Hearing explains that the member will continue to receive services if a hearing is requested until after a decision is made.

The member also receives written information about the right to request a Fair Hearing and the steps in the process regarding appeals with respect to services. The member is to use the LD-1 form to file a request. The LD-1 form is to be mailed to:
Oklahoma Health Care Authority
Grievance Docket Clerk
Legal Division
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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Unduplicated Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>22021</td>
</tr>
<tr>
<td>Year 2</td>
<td>22731</td>
</tr>
<tr>
<td>Year 3</td>
<td>23615</td>
</tr>
<tr>
<td>Year 4</td>
<td>24337</td>
</tr>
<tr>
<td>Year 5</td>
<td>24895</td>
</tr>
</tbody>
</table>

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>
<thead>
<tr>
<th>Waiver Year</th>
<th>Maximum Number of Participants Served At Any Point During the Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td></td>
</tr>
</tbody>
</table>

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):
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:

The ADvantage waiver provides for the entrance of all eligible persons.

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 is included, 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 spenddown 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 five-year period beginning January 1, 2014, 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 December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (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:

  If the member lives in their own home, the needs allowance is set equal to the special income level for institutionalized at 300% of the SSI Federal Benefit Rate (FBR).
If the member lives in an Assisted Living Center, the needs allowance is set equal to 150% of the SSI Federal Benefit Rate (FBR).

- 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:

If the member lives in their own home, the needs allowance is set equal to the special income level for institutionalized at 300% of the SSI Federal Benefit Rate (FBR).

If the member lives in an Assisted Living Center, the needs allowance is set equal to 150% of the SSI Federal Benefit Rate (FBR).

Other

Specify:

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:

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

- Health insurance premiums, deductibles and co-insurance charges
- 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.


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.


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.


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 an entity under contract with the Medicaid agency.
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:

Registered nurse, licensed in the State of Oklahoma. The nurse is an employee of OKDHS and has successfully completed the Uniform Comprehensive Assessment Tool training.

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.

317:35-17-2. Level of care medical eligibility determination
The OKDHS area nurse, or nurse designee, determines medical eligibility for ADvantage program services based on the OKDHS nurse's Uniform Comprehensive Assessment Tool (UCAT) III assessment and the determination that the member has unmet care needs that require ADvantage or NF services to assure member health and safety.

(2) Minimum UCAT criteria. The minimum UCAT criteria for NF level of care criteria are:

(A) The UCAT documents need for assistance to sustain health and safety as demonstrated by:
   (i) either the ADLs or MSQ score is in the high risk range; or
   (ii) any combination of two or more of the following:
       (I) ADLs score is at the high end of moderate risk range; or,
       (II) MSQ score is at the high end of moderate risk range; or,
       (III) IADLs score is in the high risk range; or,
       (IV) Nutrition score is in the high risk range; or,
   (V) Health Assessment is in the moderate risk range, and, in addition,
   (B) The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:
       (i) Member Support is moderate risk; or,
       (ii) Environment is high risk; or,
       (iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of need and (B) of absence of support are met;
   (C) The UCAT documents that:
       (i) the member has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet OAC 317:35-17-2(2)(A) criteria if untreated; and
       (ii) the member previously has required Hospital or NF level of care services for treatment related to the condition; and
       (iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and
       (iv) only by means of ADvantage Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

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:

For initial level of care (LOC), the OKDHS nurse assesses the applicant in his/her home using the Uniform Comprehensive Assessment Tool (UCAT). The OKDHS determines level of care based upon the assessment.

For LOC reassessment, the member’s Case Manager (CM) as part of annual service plan review and development assesses the member in his/her home using the UCAT. Information from the UCAT required for level of care determination is forwarded to the OKDHS (the Operating Agency) for level of care reevaluation/determination.

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:

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):*

- OKDHS Aging Services Division’s web-based computer system, ELDERS, monitors LOC recertification processing on all long term care members. LOC re-certifications are tracked in ELDERS database system based on the certification end date. ADvantage waiver cases auto-populate to the assigned Nurses’ Recertification tab 90 days prior to certification end date and remain flagged until the LOC recertification is completed.
- Member periodic reassessment is a component part of case management and is required annually as part of the annual service plan reevaluation process. The OKDHS ADvantage Administration (AA) monitors timely submission of UCAT documentation from Case Managers for the annual re-evaluation of service plans and for LOC recertification.

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:

Oklahoma Department of Human Services (OKDHS)

**Appendix B: Evaluation/Reevaluation of Level of Care**

**Quality Improvement: Level of Care**

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

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of applicants' initial Level of Care evaluations performed prior to entering the waiver. Numerator: Number of applicants' initial level of care evaluations completed prior entering the waiver Denominator: Total number that entered the waiver

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

**Performance Measure:**

Number and Percent of members who received an annual re-determination of eligibility within 12 months of their last determination/evaluation. **Numerator:**

Number of members who received an annual redetermination within 12 months of the target month. **Denominator:** Total number of members.

**Data Source** (Select one):

Other

If 'Other' is selected, specify: **ELDERS**

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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:
Percentage of member LOC determinations completed that used the LOC Uniform Comprehensive Assessment Tool (UCAT) instrument. Numerator: # members with LOC determinations based upon the UCAT Denominator: Total number of members’ LOC determinations

Data Source (Select one):
Other
If ‘Other’ is selected, specify:
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Performance Measure:
Number and Percentage of member LOC determinations completed by a qualified evaluator. Numerator: # members with LOC determinations made by a qualified evaluator Denominator: Total number of member LOC determinations

Data Source (Select one):
Other
If 'Other' is selected, specify:
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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. OHCA and OKDHS 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. The OHCA dedicated waiver staff will maintain administrative authority through the use of an electronic database designed for storing information received related to problems identified and resolutions of these matters. The OHCA Director of Waiver Administration and Development will be directly responsible for mediating any individual problems pertaining to administrative authority. The Director of Waiver Administration and Development will work with the designated OKDHS Point of Contact to resolve any problems in a timely manner.

Individual problems may be discovered during monitoring activities by the State or by any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring are described in each performance measure of this appendix.
The options for remediation are listed below.

Remediation for Level of Care Assurances:

• Number and percentage of initial Level of Care evaluations performed for members prior to entering the waiver.
• Number and percentage of member LOC determinations completed that used the LOC Uniform Comprehensive Assessment Tool (UCAT) instrument.
• Number and percentage of members who received an annual re-determination of eligibility within 12 months of their initial LOC determination evaluation or within 12 months of their last determination/evaluation.
• Number and Percentage of member LOC determinations completed by a qualified evaluator.

OKDHS staff monitor that Level of Care (LOC) determinations are performed in accordance with waiver and Medicaid Agency policy. If any instances are found in which a member entered the waiver prior to having an initial LOC determination, or that a LOC determination was made that was not based upon the UCAT, or that a member did not receive a re-determination of LOC eligibility within 12 months of their most recent LOC certification, or that a LOC determination was not made by a qualified evaluator, the OKDHS Nurse Programs Assistant Administrator (NPAA) contacts directly for resolution the Area Nurse responsible for the LOC evaluation within the geographic area in which the failure occurred and, if deemed necessary, the OKDHS NPAA will be required to submit, within five working days of request, a corrective action plan to the OKDHS HCBS Unit Programs Administrator.

If as part of remediation, a corrective action plan is required, the plan will detail the steps to be taken to prevent future performance failures along with the timeframe, not to exceed 30 days, for implementation of the corrective actions. Any performance failures, or remediation corrective actions, that may result in a loss of eligibility or reduction of services for one or more individual members will be referred to the EOCC for appropriate follow-up to safeguard the health and safety of members affected.

Quarterly, OKDHS will provide reports of remediation and corrective action plans (if any) to the ADvantage QMSC and to the OHCA Director of Waiver Administration and Development.

ii. Remediation Data Aggregation

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

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| ☑ 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).

i. Description of procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver:
   During the assessment visit, the OKDHS nurse informs the member and family of agencies certified to deliver ADvantage case management and in-home care services in the local area to obtain the member's primary and secondary informed choices of service providers.

If the member and/or family declines to make a provider choice, the nurse documents that decision on the member choice form (ADv-01). The OKDHS ADvantage Administration (AA) uses a rotating system to select an agency for the member from a list of all local certified case management and in-home care agencies.

The nurse documents the names of the chosen agencies and the agreement (by dated signature) of the member to receive services provided by the agencies.

Within the service plan development process, all ADvantage service options available to meet the member’s identified needs are discussed with the member and/or his/her legal representative, including the identification of ADvantage certified service providers available in the member’s area for each service option. The member (and/or his/her legal representative), in consultation with the rest of the Interdisciplinary Team (IDT), decides on specific services and service providers to meet the member’s care needs. The case manager develops the service plan that identifies services, service provider, funding source, units and frequency of service and service cost, cost by funding source and total cost for ADvantage services. The member signs and indicates review/agreement with the service plan by indicating acceptance or non-acceptance of the plan.

ii. Description of the State’s procedures for allowing individuals to choose either institutional or home and community-based services:
   As part of the assessment and eligibility process, members (and/or his/her legal guardian or representative) are informed, both verbally and in writing, of the care alternatives of (1) institutional and (2) home and community based services. The member (or legal guardian, if applicable) indicates his/her choice of long-term care setting for service delivery by signing the Freedom of Choice form (ADv-01)).

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.

Copies of member Freedom of Choice documentation are maintained in member files at the OKDHS ADvantage Administration offices.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficiency 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
Whenever a member has limited proficiency in English, a telephone interpretive service is accessed to support the communication process. The state contracts with interpreters to provide translation services when needed. Additionally, Teelanguage®, a contracted telephone translation service, is also available for use by state staff when needed. The state also contracts for the provision of interpreter services for the hearing impaired.

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:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Service</td>
<td>Adult Day Health</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Case Management</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Personal Care</td>
</tr>
<tr>
<td>Statutory Service</td>
<td>Respite</td>
</tr>
<tr>
<td>Extended State Plan Service</td>
<td>Prescribed Drugs</td>
</tr>
<tr>
<td>Extended State Plan Service</td>
<td>Skilled Nursing</td>
</tr>
<tr>
<td>Other Service</td>
<td>Advanced Supportive/Restorative Assistance</td>
</tr>
<tr>
<td>Other Service</td>
<td>Assisted Living Services</td>
</tr>
<tr>
<td>Other Service</td>
<td>Consumer-Directed Personal Assistance Services</td>
</tr>
<tr>
<td>Other Service</td>
<td>Environmental Accessibility Modifications</td>
</tr>
<tr>
<td>Other Service</td>
<td>Home-Delivered Meals</td>
</tr>
<tr>
<td>Other Service</td>
<td>Hospice Care</td>
</tr>
<tr>
<td>Other Service</td>
<td>Institution Transition Services</td>
</tr>
<tr>
<td>Other Service</td>
<td>Nursing</td>
</tr>
<tr>
<td>Other Service</td>
<td>Personal Emergency Response Systems</td>
</tr>
<tr>
<td>Other Service</td>
<td>Specialized Medical Equipment and Supplies</td>
</tr>
<tr>
<td>Other Service</td>
<td>Therapy Services</td>
</tr>
</tbody>
</table>

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 Service Type:

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

**Category 1:**

04 Day Services

Service Definition (Scope):
encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not

Physical, occupational, and speech therapies are defined under skilled therapy services. Therapy service, when indicated in the recipient's basis as an Enhancement to basic Adult Day Health Care.

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

Amount, frequency and duration of service are prior authorized in accordance with service plan. Adult Day Health service addition to standard Adult Day Health service units. Adult Day Health Personal Care Enhancement is a maximum one unit

If a member requires assistance with ADL/IADL needs beyond what may be provided through Adult Day Health, the member may also receive personal care during a period of time when the person is being served in an Adult Day Health Center, the member will be served by the Center, and the individual being served is being provided assistance with ADL/IADL needs.

AA/SPA will review service plans to ensure that duplication of services does not occur.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Therapist</td>
</tr>
<tr>
<td>Agency</td>
<td>Adult Day Care Center</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:
- Individual

Provider Type:
- Therapist

Provider Qualifications
License (specify):
Physical Therapist - 59 O.S. Sec. 888.1, et seq.; Occupational Therapist - 59 O.S. Sec. 887.1, et seq.; or Speech/Language Therapist - 59 O.S. Sec. 886.1, et seq.
Certificate (specify):
None

Other Standard (specify):
Employed by the ADvantage Adult Day Health Center

Verification of Provider Qualifications
Entity Responsible for Verification:
Adult Day Care provider
Frequency of Verification:
Re-verified as necessary

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 Center

Provider Qualifications
License (specify):
Adult Day Care Center
56 O.S., Sec. 1-177, et seq.
Certificate (specify):
None

Other Standard (specify):
• ADvantage Qualified Provider Certification [OAC 3 17:30-5-761]
• Medicaid Provider Contract

Verification of Provider Qualifications
Entity Responsible for Verification:
Oklahoma Department of Human Services
Frequency of Verification:
Prior to Enrollment and 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 Service Type:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:
01 Case Management

Category 2:

Category 3:

Category 4:

services, regardless of payment source of services that may benefit the member in maintaining health and safety. Case managers initiate and the member, as determined through assessments. Case managers are responsible for ongoing monitoring of the provision of services included in the individual's plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service are prior authorized in accordance with service 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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Home Care Case Management</td>
</tr>
<tr>
<td>Agency</td>
<td>Case Management Agency</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency

Provider Type:
Home Care Case Management

Provider Qualifications
License (specify):
Home Care Agency
63 O.S., Sec. 1-1961, et seq.

Certificate (specify):

Other Standard (specify):
• ADVantage Qualified Provider Certification [OAC 317:30-5-761]
• Medicaid Provider Contract
• Minimum qualifications for Case Manager are:
  1. RN with one year paid professional experience; or
2. LPN with one year paid professional experience; or
3. Baccalaureate degree and one year *paid professional experience with the aging or disabled population obtained
4. [*Paid professional experience may include, but is not limited to: CNA, CMA, CHHA or PCA experience.]
5. A minimum of one week of orientation to the agencies policies and procedures to include shadowing a certified training provider.

Training Requirements: All case managers must successfully complete the ADvantage Program Case Manager Training.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Oklahoma Department of Human Services

**Frequency of Verification:**
Prior to Enrollment and Annually

### Appendix C: Participant Services

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

<table>
<thead>
<tr>
<th>Provider Category:</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Type:</td>
<td>Case Management Agency</td>
</tr>
</tbody>
</table>

**Provider Qualifications**

- **License (specify):** None
- **Certificate (specify):** None
- **Other Standard (specify):**
  - ADvantage Qualified Provider Certification [OAC 317:30-5-761]
  - Medicaid Provider Contract
  - Minimum qualifications for Case Manager are:
    1. RN with one year paid professional experience; or
    2. LPN with one year paid professional experience; or
    3. Baccalaureate degree and one year *paid professional experience with the aging or disabled population obtained [*Paid professional experience may include, but is not limited to: CNA, CMA, CHHA or PCA experience.]
    4. A minimum of one week of orientation to the agencies policies and procedures to include shadowing a certified training provider.

Training Requirements: All case managers must successfully complete the ADvantage Program Case Manager Training.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Oklahoma Department of Human Services

**Frequency of Verification:**
Prior to Enrollment and 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

**Service Type:**

- Statutory Service

**Service:**

- Personal Care
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:
08 Home-Based Services

Category 2:

Category 3:

Category 4:

bathing, dressing, personal hygiene activities of daily living. These services may include assistance with preparation of meals to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family

Personal care services under the State plan differ in service definition from the services offered under the waiver including care. The scope, nature and provider type including waiver certification require more quality planning and action by agencies delivering ADvantage waiver personal care. This level of quality supervision of personal care providers will be furnished by a registered nurse, licensed to practice nursing in the State or 6 months or more often as required by the service plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service: Amount, frequency and duration of service are prior authorized in accordance with service 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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Personal Care</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Provider Category:
Agency: Personal Care

Provider Qualifications:
- **License (specify):**
  - Home Care Agency
  - 63 O.S., Sec. 1-1961, et seq.
- **Certificate (specify):** None
- **Other Standard (specify):**
  - ADvantage Qualified Provider Certification [OAC 317:30-5-761]
  - Medicaid Provider Contract
  - The PCA is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq., l
  - Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification.

  Training Requirements: Demonstrates competency to a qualified evaluator to meet the personal care assistance needs.

Nurse Supervision Requirements:
Registered nurse (RN) supervision of Personal Care services is a state requirement of the Medicaid Program. Each designate the qualifications of the supervisor. While some of the nursing supervision functions may be delegated to a licensed practical nurse (LPN), At a minimum the provider agency must meet services quality monitoring and oversight requirements in accordance with the RN. The RN has the responsibility of determining the status of the present plan of care in meeting the member’s needs.

Verification of Provider Qualifications:
- **Entity Responsible for Verification:** Oklahoma Department of Human Services
- **Frequency of Verification:** Prior to Enrollment and 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 Service Type:
- **Statutory Service**

Service:
- Respite

Alternate Service Title (if any):

HCBS Taxonomy:

**Category 1:**
- 09 Caregiver Support

**Category 2:**
- 09 Caregiver Support

**Category 3:**
Category 4:

unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons:

Respite care will be provided in the following locations:

- In-Home Respite in the individual's home or place of residence;
- Respite required for periods of time of seven or less hours in a day may be authorized in 15-minute unit increments to a maximum of 28 units per day.
- Extended In-home Respite defined as respite required for periods of time of more than seven (7) hours in a day are authorized at a per diem rate.

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

Amount, frequency and duration of service are prior authorized in accordance with service 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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Home Care</td>
</tr>
<tr>
<td>Agency</td>
<td>Nursing Facility</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Home Care
Provider Qualifications

License (specify):
Home Care Agency
63 O.S., Sec. 1-1961, et seq.

Certificate (specify):
None

Other Standard (specify):
- ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- Medicaid Provider Contract
- Respite provider is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq.
- Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references

Verification of Provider Qualifications
Entity Responsible for Verification:
Oklahoma Department of Human Services

Frequency of Verification:
Prior to Enrollment and Annually
### Appendix C: Participant Services

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

<table>
<thead>
<tr>
<th>Service Type:</th>
<th>Statutory Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Name:</td>
<td>Respite</td>
</tr>
</tbody>
</table>

**Provider Category:**
- Agency

**Provider Type:**
- Nursing Facility

**Provider Qualifications**
- **License (specify):**
  - Nursing Facility
  - 63 O.S., Sec. 1-1901, et seq.
- **Certificate (specify):**
  - None
- **Other Standard (specify):**
  - ADvantage Qualified Provider Certification [OAC 317:30-5-761]
  - Medicaid Provider Contract

**Verification of Provider Qualifications**
- **Entity Responsible for Verification:**
  - Oklahoma Department of Human Services
- **Frequency of Verification:**
  - Prior to Enrollment and 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

<table>
<thead>
<tr>
<th>Service Type:</th>
<th>Extended State Plan Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Title:</td>
<td>Prescribed Drugs</td>
</tr>
</tbody>
</table>

**HCBS Taxonomy:**

**Category 1:**
- 11 Other Health and Therapeutic Services

**Category 2:**
- 

**Category 3:**
- 

**Category 4:**
- 

https://wms-mmdl.cdssvc.com/WMS/faces/protected/35/print/PrintSelector.jsp

1/20/2015
available through the approved State Plan will be provided, except that the limitations on amount, duration and scope will request by reference. These services will be provided under the State plan until the plan limitations have been reached.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Amount, frequency and duration of service is prior authorized. Prescribed drugs available under Medicare Part D will no drugs per recipient per month. For waiver recipients who may require more than thirteen (13) prescriptions per month (b determination of medical necessity for the additional prescription product(s) being requested, this review could result in prescription drug coverage.

The service is authorized by the member's ADvantage Service Plan and is necessary to prevent institutionalization.

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

- [ ] Participant-directed as specified in Appendix E
- [x] Provider managed

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

- [ ] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

**Provider Specifications:**

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Pharmacy</td>
</tr>
</tbody>
</table>

**Appendix C: Participant Services**

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

**Provider Category:**

* [ ] Agency

**Provider Type:**

* Pharmacy

**Provider Qualifications**

* License *(specify):*
  * Pharmacist
  * 59 O.S. Sec. 353.9, et seq.
* Certificate *(specify):*
  * None
* Other Standard *(specify):*
  * Medicaid Provider Contract

**Verification of Provider Qualifications**

* Entity Responsible for Verification:
  * Oklahoma Health Care Authority
* Frequency of Verification:
  * Prior to Enrollment and 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

**Service Type:**
Extended State Plan Service  

**Service Title:**
Skilled Nursing

**HCBS Taxonomy:**

**Category 1:**
05 Nursing  

**Category 2:**

**Category 3:**

**Category 4:**

Nursing: Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are ordered licensed to practice in the State.

Skilled Nursing services provided in the member's home or other community setting are services requiring the specialize nursing services furnished under SoonerCare plan limits are exhausted. The Oklahoma MMIS forces payment of Medicare, then State Plan Medicaid and then ADvantage to prevent Skilled Nursing services are provided on an intermittent or part-time basis and provided on a per visit basis. These intern

The provision of the Skilled Nursing service will prevent institutionalization of the member.  

Specify applicable (if any) limits on the amount, frequency, or duration of this service:  
Amount, frequency and duration of service are prior authorized in accordance with service plan.

It is the responsibility of the RN to contact the member's physician to obtain any necessary information or orders pertain

The Oklahoma MMIS forces payment of Medicare, then State Plan Medicaid and then ADvantage to prevent duplicatio

**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:**

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Skilled Nursing</td>
</tr>
</tbody>
</table>
Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Skilled Nursing

Provider Category:
Agency

Provider Type:
Skilled Nursing

Provider Qualifications
License (specify):
Registered Nurse; Licensed Practical Nurse licensed under the Nurse Practice Act -- 59 O.S. Sec. 567.1 through 56

Employed by a Home Care Agency
63 O.S., Sec. 1-1961, et seq.;
Certificate (specify):

Other Standard (specify):
• ADVantage Qualified Provider Certification [OAC 317:30-5-761]
• Medicaid Provider Contract

Verification of Provider Qualifications
Entity Responsible for Verification:
Oklahoma Department of Human Services
Frequency of Verification:
Prior to Enrollment and 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 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:
Advanced Supportive/Restorative Assistance

HCBS Taxonomy:

Category 1:
08 Home-Based Services

Category 2:

Category 3:
Category 4:

Supportive/Restorative Care services are maintenance services provided to assist a member with a stable, chronic condition with activities of daily living when such assistance requires Advanced Supportive/Restorative Care. This service is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical services.

Examples of Advanced Supportive/Restorative Care services which may be performed are:

- Routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies);
- Remove external catheters, inspect skin and reapplication of same;
- Administer prescribed bowel program including use of suppositories and sphincter stimulation, or
- Apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;
- Use lift for transfers;
- Manually assist with oral medications which are set up by a registered or licensed practical nurse;
- Provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;
- Apply non-sterile dressings to superficial skin breaks or abrasions as directed by a registered or licensed professional;
- Use Universal precautions as defined by the Center for Disease Control.

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

Amount, frequency and duration of service is prior authorized in accordance with service plan.

AA/SPA, in reviewing service plan requests for Advanced Supportive/Restorative Assistance will not give approval if personal care.

Service Delivery Method (check each that applies):

- [ ] Participant-directed as specified in Appendix E
- [x] Provider managed

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

- [x] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Home Care</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Advanced Supportive/Restorative Assistance

Provider Category:
- [ ] Agency

Provider Type:
- Home Care

Provider Qualifications

- License (specify):
  - Home Care License
  - 63 O.S., Sec. 1-1961, et seq.
- Certificate (specify):
  - None
- Other Standard (specify):
• ADvantage Qualified Provider Certification [OAC 317:30-5-761]
• Medicaid Provider Contract
• The ASR Assistant is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq., has no pending charges, demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references.

Training Requirements: All Advanced Supportive/Restorative Assistance aides are required to receive the same basic Personal Care training as a Personal Care aide.

The Provider must provide to its staff Advanced Supportive/Restorative Assistance training specific to the care needs of the individual being served.

• Observing the member and reporting observations;
• Application of ointments/lotions to unbroken skin;
• Supervise/assist with oral medications;
• Prevention of skin breakdown;
• Bowel program;
• Basic Personal Care for persons with ostomies and catheters;
• Range of motion exercises;
• Use of lift for transfers;
• Applying non-sterile dressings to superficial skin breaks; and
• Universal precaution procedures as defined by the Center for Disease Control.

The provider must document the dates and hours of Advanced Supportive/Restorative Assistance training received.

Prior to performing any Advanced Supportive/Restorative Assistance task for any member for the first time, the aide must document the aide's competency in performing each task in the aide's personnel file. The RN/LPN visit required to demonstrate the aide's competency in performing each Advanced Personal Care task during an on-the-job training session with a RN/LPN may not be conducted by an aide.

The Advanced Supportive/Restorative Assistance provider shall have written documentation of all basic and in-service training provided which includes the topics, number of hours, and location; the date of first supervised service delivery; and shall contain the worker's signature.

Nurse Supervision Requirements:

Registered nurse supervision is essential to the safe provision of Advanced Supportive/Restorative Care services. The registered nurse must:

• Conduct an initial assessment visit and develop the plan of care for members with Advanced Supportive/Restorative Care needs, in collaboration with the case manager.
• Conduct on-site visits to all Advanced Supportive/Restorative Care members at six-month intervals. During the visit, the RN shall conduct an initial assessment visit and develop the plan of care for all subsequent years for members.
• Make periodic member evaluations, on a schedule as prescribed by the service plan and paid for by ADvantage, and make evaluation reports available to the case manager.
• Attend IDT meetings to establish or amend the Service Plan.
• Be available, at least by telephone, during any period of time Advanced Supportive/Restorative Care is being provided.
• Observe the successful execution by the aide of each Advanced Supportive/Restorative Care task during an on-the-job training session with a RN/LPN.

The licensed practical nurse may:

• Conduct the periodic authorized nurse visits to evaluate the condition of the Advanced Supportive/Restorative Care member.

Verification of Provider Qualifications

Entity Responsible for Verification:
Oklahoma Department of Human Services

Frequency of Verification:
Prior to Enrollment and 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 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: Assisted Living Services

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Category 2:

Category 3:

Category 4:

Services: Personal care and supportive services that are furnished to waiver members who reside in a homelike, non-institutional setting that includes 24-hour assistance (to the extent permitted under State law). Services that are provided by third parties must be coordinated with housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, transportation to and from medical appointments. Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the participant. Room and board, items of comfort or convenience, or the costs of facility maintenance, transportation to and from medical appointments, are not available for this service.

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

Amount, frequency and duration of service is prior authorized in accordance with service plan.

AA/SPA in reviewing service plan requests for Assisted Living will ensure that duplicative services are not authorized.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<tbody>
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<td>Assisted Living</td>
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</table>

https://wms-mmdl.cdsvd.com/WMS/faces/protected/35/print/PrintSelector.jsp
Appendix C: Participant Services

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

| Service Type: Other Service |
| Service Name: Assisted Living Services |

Provider Category:
Agency

Provider Type:
Assisted Living

Provider Qualifications
License (specify):
63 O.S. Sec. 1-890.1 et seq.
Assisted Living Center

Certificate (specify):
None

Other Standard (specify):
• ADvantage Qualified Provider Certification [OAC 317:30-5-761; see Appendix C-2: 3-10 for standards in additc
• In addition, ADvantage certification requires ALC to meet the following Quality Assurance/ Quality Improvemer
• The ALC shall have a written quality improvement plan that addresses the following:
• Organizational structure, which includes, but is not limited to the existence of an organization chart and job descr
• Written Polices and Procedures which provide for a member complaint and grievance process, a member satisfact
• A Quality Assurance System which provides for self audits and corrective action and member satisfaction evaluat
• Management Reports.
• Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:
Oklahoma Department of Human Services

Frequency of Verification:
Prior to Enrollment and 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

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 sț

Service Title:
Consumer-Directed Personal Assistance Supports and Services

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Category 2:

Service Definition (Scope):
Services Assistance and Advanced Personal Services Assistance that enable an individual in need of assistance to reside

Personal Services Assistance (PSA)

The service of Personal Services Assistance may include:
- Assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both.
- Assistance with routine bodily functions that may include:
  - Bathing and personal hygiene;
  - Dressing and grooming;
  - Eating including meal preparation and cleanup; and
  - Companion type service assistance that may include letter writing, reading, mail and providing escort or transportation to participate in approved activities or events.

Advanced Personal Services Assistance (APSA)

Advanced Personal Services Assistance are maintenance services provided to assist a member with a stable, chronic condition with activities of daily living when such assistance physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as attending physician who may, if appropriate, order home health services.

The Personal Services Assistant hired by the member is responsible for delivery of Personal Services Assistance required.

Provider type/mode of service delivery:
- Personal Care Assistance services are provided by a worker (PCA) employed by a licensed Home Care Agency following a plan developed and supervised by a Home Care Agency nurse.
- Personal Services Assistance services are provided by a worker (PSA) employed by the member receiving services following a plan.

Service definition
- There is overlap in service definition in that both services are to meet ADL and/or IADL needs of the member. However, authorization through the service planning process.

Scope of services
- PSA services may include companion type service assistance that may include letter writing, reading, mail and provide

Advanced Personal Services Assistance (APSA)

Advanced Personal Services Assistance are maintenance services provided to assist a member with a stable, chronic condition who may be physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as a

The service of Advanced Personal Services Assistance includes assistance with Health Maintenance activities that may include:
- Routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies with:
  - Remove external catheters, inspect skin and reapplication of same;
  - Administer prescribed bowel program including use of suppositories and pamphlets on bowel care;
  - Apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;
  - Use lift for transfers;
  - Manually assist with oral medications;
  - Provide passive range of motion (non-resistive flexion of joint) delivered in accordance to a plan of care developed by a certified occupational therapist or physical therapist, and re-appraised as needed;
  - Apply non-sterile dressings to superficial skin break or abrasions; and
  - Use Universal precautions as defined by the Center for Disease Control.

Prior to performing any Advanced Personal Services Assistance task for any member for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session, and certify the successful completion of the training. When deemed necessary by the CM/CDA, ADvantage Nursing services are authorized by the

The service of Advanced Personal Services Assistance task during an on-the-job training session, and c
The Advanced Personal Services Assistant hired by the member is responsible for delivery of Advanced Personal Services Assistance required by the member and authorized on the service.

Goods and Services

Incidental goods and/or services necessary to support the Member/Employer in carrying out Employer responsibilities or documentation to verify that the purchase is necessary to support the Member/Employer in carrying out Employer responsibilities or for delivery of authorized CD documentation to verify that the purchase is necessary to support the Member/Employer in carrying out Employer responsibilities or for delivery of the authorized CD goods and services are retained by the FMS.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service is prior authorized in accordance with service plan.

Service Delivery Method (check each that applies):

- [x] Participant-directed as specified in Appendix E
- [ ] Provider managed

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

- [x] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

Provider Specifications:

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<th>Provider Type Title</th>
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<tbody>
<tr>
<td>Individual</td>
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<tr>
<td>Individual</td>
<td>Advanced Personal Services Assistant</td>
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Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer-Directed Personal Assistance Supports and Services

Provider Category: Individual
Provider Type: Personal Services Assistant

Provider Qualifications
- License (specify): None
- Certificate (specify): None
- Other Standard (specify):
  - Medicaid Provider Contract
  - The Assistant is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq.
  - Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references
  - Training Requirements: Demonstrates competence to perform required tasks to employer/participant satisfaction.

Verification of Provider Qualifications
Entity Responsible for Verification: Employer/Participant

Employer/Participant jointly with Oklahoma Department of Human Services for criminal and abuse registry background checks
Frequency of Verification:
Prior to enrollment and re-verified as necessary
Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Consumer-Directed Personal Assistance Supports and Services

**Provider Category:** Individual

**Provider Type:** Advanced Personal Services Assistant

**Provider Qualifications**

- **License (specify):** None
- **Certificate (specify):** None
- **Other Standard (specify):**
  - Medicaid Provider Contract
  - The Assistant is at least 18 years of age, has no been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq,
  - Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references,
  - Training Requirements: Demonstrates competence to perform required tasks to employer/participant satisfaction.
  - Prior to performing any Advanced Personal Services Assistance task for any member for the first time, the APSA deemed necessary by the CM/CDA, ADvantage Nursing services are authorized to provide assistance with training

**Verification of Provider Qualifications**

- **Entity Responsible for Verification:** Employer/Participant

  Employer/Participant jointly with Oklahoma Department of Human Services for criminal background and abuse references

  **Frequency of Verification:** Prior to enrollment and re-verified as necessary

---

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

**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 Modifications

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Category 2:**

**Service Definition (Scope):**
Category 3:

Category 4:

ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence: specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies whi central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benef

All services shall be provided in accordance with applicable State or local building codes and conforms to ADA Accessi The service is authorized by the member’s ADvantage Service Plan and is necessary to prevent ins Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service are prior authorized in accordance with service 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:

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<th>Provider Type Title</th>
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<tr>
<td>Individual</td>
<td>Plumbers</td>
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<tr>
<td>Individual</td>
<td>Mechanical Contractors</td>
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<tr>
<td>Individual</td>
<td>Re-modelers and Builders</td>
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<tr>
<td>Individual</td>
<td>Electrician</td>
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<tr>
<td>Individual</td>
<td>Architects</td>
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</tbody>
</table>

Appendix C: Participant Services

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

| Service Type: Other Service
| Service Name: Environmental Accessibility Modifications

Provider Category:
Individual

Provider Type:
Engineers

Provider Qualifications

License (specify):
An Act Regulating Professional Engineers and Land Surveyors, 59 O.S., Sec. 475.1 et seq.

Certificate (specify):
None

Other Standard (specify):
• ADvantage Qualified Provider Certification [OAC 317:30-5-761]
• Medicaid Provider Contract
Appendix C: Participant Services

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

| Service Type: Other Service |
| Service Name: Environmental Accessibility Modifications |

Provider Category: Individual

Provider Type: Plumbers

Provider Qualifications

License (specify):
Plumbing Licensing Act, 59 O.S., Sec. 1001-1021

Certificate (specify):
None

Other Standard (specify):
- ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- Medicaid Provider Contract
- ADA Accessibility Guidelines – 28 CFR Part 36 Appendix A.

Verification of Provider Qualifications

Entity Responsible for Verification:
Oklahoma Department of Human Services

Frequency of Verification:
Prior to Enrollment and Annually

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Modifications

Provider Category: Individual

Provider Type: Mechanical Contractors

Provider Qualifications

License (specify):
Mechanical Licensing Act, 59 O.S., Sec. 1850.1-1850.15

Certificate (specify):
None

Other Standard (specify):
- ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- Medicaid Provider Contract
- ADA Accessibility Guidelines – 28 CFR Part 36 Appendix A.

Verification of Provider Qualifications

Entity Responsible for Verification:
Oklahoma Department of Human Services

Frequency of Verification:
Prior to Enrollment and Annually
Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Modifications

Provider Category:
[Individual]

Provider Type:
Re-modelers and Builders

Provider Qualifications

License (specify):
None

Certificate (specify):
None

Other Standard (specify):
• ADvantage Qualified Provider Certification [OAC 317:30-5-761]
• Medicaid Provider Contract
• ADA Accessibility Guidelines – 28 CFR Part 36 Appendix A.

Verification of Provider Qualifications

Entity Responsible for Verification:
Oklahoma Department of Human Services

Frequency of Verification:
Prior to Enrollment and Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Modifications

Provider Category:
[Individual]

Provider Type:
Electrician

Provider Qualifications

License (specify):
Electricians Licensing Act, 59 O.S., Sec. 1680 et seq.

Certificate (specify):
None

Other Standard (specify):
• ADvantage Qualified Provider Certification [OAC 317:30-5-761]
• Medicaid Provider Contract
• ADA Accessibility Guidelines – 28 CFR Part 36 Appendix A.

Verification of Provider Qualifications

Entity Responsible for Verification:
Oklahoma Department of Human Services

Frequency of Verification:
Prior to Enrollment and Annually
Appendix C: Participant Services

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

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Service Name</td>
<td>Environmental Accessibility Modifications</td>
</tr>
</tbody>
</table>

Provider Category:

- Individual

Provider Type:

- Architects

Provider Qualifications

- License (specify):
  - Architects Oklahoma Administrative Code Title 55, Chapter 10

- Certificate (specify):
  - None

- Other Standard (specify):
  - ADvantage Qualified Provider Certification [OAC 317:30-5-761]
  - Medicaid Provider Contract
  - ADA Accessibility Guidelines – 28 CFR Part 36 Appendix A.

Verification of Provider Qualifications

- Entity Responsible for Verification:
  - Oklahoma Department of Human Services

- Frequency of Verification:
  - Prior to Enrollment and 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

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:

- Home-Delivered Meals

HCBS Taxonomy:

- Category 1:
  
  06 Home Delivered Meals

- Category 2:

- Category 3:

- Category 4:
Home-delivered Meal services provide meals, each with a nutritional content equal to one-third of the Dietary Reference by providing meals in a cost-effective manner.

Home-delivered Meals shall be included in the individual service plan only when it is necessary to prevent the permanent

The goals of Home-Delivered Meals
(1) To facilitate member independence by allowing members the choice to remain in his/her own home rather than enter
(2) To provide one daily nutritious meal to persons at risk of being institutionalized.

In order to receive Home-delivered Meals under the waiver, a member must:
(1) Be unable to prepare some or all of his/her own meals, or requires a special diet and is unable to prepare meals; or
(2) Have no other individual available to prepare member's meals, or the provision of a Home-delivered Meal is the mos

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service is prior authorized in accordance with service plan; however, one (1) meal is

Safeguards:
If a member needs assistance with meals beyond the service limits for ADvantage home delivered meals, the memberÂ‚ for the member to obtain meals from an Older American Act congregate meal site and/or arranges for ADvantage Personal Care Pantry.

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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
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<tbody>
<tr>
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<td>Home-Delivered Meals</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home-Delivered Meals

Provider Category:
Agency

Provider Type:
Home-Delivered Meals

Provider Qualifications
License (specify):
Oklahoma Health Code, Food Preparers/Handlers License -
Sec. 1110 & 1119
59 O.S. Sec. 21
or equivalent Food Preparers License from the state where the kitchen facility is located.

Certificate (specify):
County Health Department
Kitchen Cert & Food Handlers Certification
or equivalent Certification from the state where the kitchen facility is located or evidence that the kitchen is USDA
Other Standard (specify):
ADvantage Qualified Provider Certification [OAC 317:30-5-761]
Medicaid Provider Contract
Title III Program Home-Delivered Meal Provider Standards.
Comply with all applicable Federal, State, and Local laws and ordinances regulating the preparation handling and

Verification of Provider Qualifications
Entity Responsible for Verification:
Oklahoma Department of Human Services
Frequency of Verification:
Prior to Enrollment and 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
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:
Hospice Care

HCBS Taxonomy:

Category 1:
08 Home-Based Services

Category 2:

Category 3:

Category 4:

Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the n which are experienced during the final stages of illness and during dying and bereavement. The member signs a stateme member’s medical care for the terminal illness in the home environment. Hospice care services include nursin and grief and bereavement counseling to the member and/or family.

A Hospice plan of care must be developed by the hospice team in conjunction with the member’s case manage hand and a glove. The hospice services must be related to the palliation or management of the member’s term provided for authorization of ADvantage Hospice services. Authorization of ADvantage Hospice services will correspon the family as individually determined for each member who receives hospice services.

A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvant
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service is prior authorized in accordance with service plan. Initial authorization is for:

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:

<table>
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<tr>
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<th>Provider Type Title</th>
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<td>Hospice Agency</td>
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Appendix C: Participant Services

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

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the:

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:
- Institution Transition Services

HCBS Taxonomy:

https://wms-mmdl.cdsvdc.com/WMS/faces/protected/35/print/PrintSelector.jsp

1/20/2015
Category 1:

01 Case Management

Category 2:

Category 3:

Category 4:

Services: Institution Transition Services are those services that are necessary to enable an individual to leave the institution.

Institution Transition Services may include:

- Case Management

Institution Transition Case Management services include member assessment, transition/move planning, monitoring of member status/readiness for setting. Reimbursement for items or services, other than case management, required for transition or establishment of community home with ADvantage services.

Institutional Transition Services may be authorized and reimbursed under the following conditions:

- The service is necessary to enable the individual to move from the institution to their home;
- The individual is eligible to receive ADvantage services outside the institutional setting;
- Institutional Transition Services are provided to the member within 180 days of discharge from the institution;
- Transition Services provided while the member is in the institution are to be claimed as delivered on the day of discharge.

Case Management Services:

Institution Transition Case Management Services are services required by the member's plan of care, which are necessary for institutionalized members that are eligible to receive ADvantage services in gaining access to community setting. Transition Case Management Services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay.

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

Amount, frequency and duration of service is prior authorized in accordance with service plan.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed (checked)

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

<table>
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<th>Provider Category</th>
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<td>Agency</td>
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Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

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<th>Service Type: Other Service</th>
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<tbody>
<tr>
<td>Service Name: Institution Transition Services</td>
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**Provider Category:**
Agency

**Provider Type:**
Case Management

**Provider Qualifications**

- **License (specify):** None
- **Certificate (specify):** None
- **Other Standard (specify):**
  - ADvantage Qualified Provider Certification [OAC 317:30-5-761]
  - Medicaid Provider Contract
  - Minimum qualifications for Case Manager are:
    1. RN with one year paid professional experience; or
    2. LPN with one year paid professional experience; or
    3. Baccalaureate degree and one year *paid professional experience with the aging or disabled population obtained [*Paid professional experience may include, but is not limited to: CNA, CMA, CHHA or PCA experience.]*
    4. A minimum of one week of orientation to the agencies policies and procedures to include shadowing a certified

**Verification of Provider Qualifications**

- **Entity Responsible for Verification:** Oklahoma Department of Human Services
- **Frequency of Verification:** Prior to Enrollment and Annually

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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

**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:**
Nursing

**HCBS Taxonomy:**

**Category 1:**

- 05 Nursing

**Category 2:**

Service Definition (*Scope*):
Category 3:

registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. The provision of the nursing service will prevent institutionalization of the member.

The nursing services, which may be authorized, are services of a maintenance or preventative nature provided to members of Programs or ADvantage Skilled Nursing. Should the nurse detect a need for services that would meet the definition of reimbursable skilled nursing care, she/he will notify the ADvantage case manager.

The ADvantage nurse's primary role is to assess the member's health and safety, develop and implement the personal care plan and/or private duty nursing plan, provide training and follow-up care for the member, and to ensure that the provider is certified and contracted to provide. Reimbursement for a nurse evaluation shall be denied if the provider that produced the nurse evaluation fails to provide the evaluation.

To comply with the Oklahoma Home Care Act, an initial registered nurse evaluation must precede personal care service delivery, must be part of the initial assessment of the member, must be performed by a provider that provides or contracts with personal care workers to provide the personal care services. To promote continuity of care, the evaluation should be performed by the same nurse that will provide the personal care services.

Nursing Supervision: As referenced in the Personal Care and Advance Supportive/Restorative Assistance Supervision Standards.

Additional services may include one or more of the following where appropriate to the needs of the member as authorized:

- Filling insulin syringes for a visually impaired diabetic who can self-inject the medication but cannot fill his own syringe.
- Setting up oral medications in divided daily compartments for a member who self-administers prescribed medications.
- Monitoring a member's skin condition when a member is at risk of skin breakdown due to immobility or incontinence.
- Conducting general health evaluations.
- Providing nail care for a member with diabetes, circulatory, neurological, vision, cognitive or mobility deficits.
- Making an on-site visit to each member for whom Advanced Supportive/Restorative Care services are authorized.
- Conducting general health evaluations.
- Providing on-the-job training and competency testing for Advanced Supportive/Restorative Assistants.
- Providing to the case manager a copy of each Nursing Evaluation (within 24 hours) or monitoring visit (within 48 hours).

The ADvantage Program case manager may recommend authorization of RN visits in other similar situations.

It is the responsibility of the RN to contact the member's physician to obtain any necessary information or orders pertaining to the service. Specify applicable limits on the amount, frequency, or duration of this service:

Amount, frequency and duration of service are prior authorized in accordance with service plan.

The Oklahoma MMIS forces payment of Medicare, then State Plan Medicaid and then ADvantage to prevent duplication of payment for skilled nurse 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:

<table>
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<td>Agency</td>
<td>Home Care</td>
</tr>
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</table>
Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Nursing

**Provider Category:**  
Agency

**Provider Type:**  
Home Care

**Provider Qualifications**

**License (specify):**
Registered Nurse; Licensed Practical Nurse licensed under the Nurse Practice Act -- 59 O.S. Sec. 567.1 through 56

Employed by a Home Care Agency  
63 O.S., Sec. 1-1961, et seq.;

**Certificate (specify):**
None

**Other Standard (specify):**
- ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- Medicaid Provider Contract

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Oklahoma Department of Human Services

**Frequency of Verification:**
Prior to Enrollment and 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

**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:**
Personal Emergency Response Systems

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Category 2:**

**Category 3:**

**Service Definition (Scope):**

https://wms-mndl.cdsvdc.com/WMS/faces/protected/35/print/PrintSelector.jsp
Category 4:

individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver comprehend the purpose of the PERS and ability to activate the PERS, have a health and safety plan detailing the interve medical condition causing the falls.

The service is authorized by the member’s ADvantage Service Plan and is necessary to prevent institutionalization. Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service is prior authorized in accordance with service 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:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Medical &amp; Rehabilitative Equipment Manufacturers and Suppliers</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems

Provider Category:
Agency

Provider Type:
Medical & Rehabilitative Equipment Manufacturers and Suppliers

Provider Qualifications
License (specify):
None
Certificate (specify):
None
Other Standard (specify):
• ADvantage Qualified Provider Certification [OAC 317:30-5-761]
• Medicaid Provider Contract

Verification of Provider Qualifications
Entity Responsible for Verification:
Oklahoma Department of Human Services
Frequency of Verification:
Prior to Enrollment and 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

**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 Equipment and Supplies

**HCBS Taxonomy:**

**Category 1:**
14 Equipment, Technology, and Modifications

**Category 2:**
14 Equipment, Technology, and Modifications

**Category 3:**

**Category 4:**

equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable members to increase their abilities to perform activities of daily proper functioning of such items, and durable and non durable medical equipment not available under the Medicaid State

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid State plan and/or supply items which are not of direct medical or remedial benefit to the waiver member. The service is applicable standards of manufacture, design and installation.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Amount, frequency and duration of service is prior authorized in accordance with service plan.

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

- [ ] Participant-directed as specified in Appendix E
- [x] Provider managed

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

- [ ] Legally Responsible Person
- [ ] Relative
- [ ] Legal Guardian

**Provider Specifications:**

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Home Care</td>
</tr>
<tr>
<td>Agency</td>
<td>Medical &amp; Rehabilitative Equipment Manufacturers and Suppliers</td>
</tr>
</tbody>
</table>
Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency

Provider Type:
Home Care

Provider Qualifications

License (specify):
Home Care License
63 O.S., Sec. 1-1961, et seq.

Certificate (specify):
None

Other Standard (specify):
• ADvantage Qualified Provider Certification [OAC 317:30-5-761]
• Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:
Oklahoma Department of Human Services

Frequency of Verification:
Prior to Enrollment and Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency

Provider Type:
Medical & Rehabilitative Equipment Manufacturers and Suppliers

Provider Qualifications

License (specify):
None

Certificate (specify):
Medicare Certification

Other Standard (specify):
• ADvantage Qualified Provider Certification [OAC 317:30-5-761]
• Medicaid Provider Contract
• Oklahoma Medical Practice Act
59 O.S., Sec. 481 through 536

Verification of Provider Qualifications

Entity Responsible for Verification:
Oklahoma Health Care Authority

Frequency of Verification:
Prior to Enrollment and prior to re-contracting
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

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:

Therapy Services

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Category 2:

11 Other Health and Therapeutic Services

Category 3:

11 Other Health and Therapeutic Services

Category 4:

SERVICES

A. General Principles Governing Reasonable and Necessary Utilization of Skilled Therapy Services.

1. The development, implementation, management, and evaluation of an individual care plan based on the physician's or therapist are needed to manage and reevaluate periodically the appropriateness of a maintenance program because of an identified danger to the member, such services would be skilled management involves a finding that the member's recovery and/or safety cannot be assured unless the total care, the skills of a therapist are needed to establish a reasonable and necessary maintenance program until it can be safely and effectively covered because the program is not yet fully established for safety and effectiveness.

2. The skilled therapy services must be reasonable and necessary to the treatment of the member's illness or injury within

   a. The services must be consistent with the nature and severity of the illness or injury and the member's particular medical needs, including the requirement that the services must be considered, under accepted standards of medical practice, to be specific and effective treatment for the member's
   
   c. The services must be provided with the expectation, based on the assessment made by the physician of the member's the condition of the member will improve materially in a reasonable and generally predictable period of time; or the services are necessary to the establishment of a safe and effective maintenance program.

If there is not a reasonable expectation of improvement in a member's condition, there may still be a need for skilled serv
d. Services of skilled therapists which are for the purpose of teaching the member or the member's family or caregivers necessary techniques, exercises, or agency staff (e.g., home health aides) are not billable as visits since the home health agency is responsible for ensuring that its staff is The following Skilled Therapy Services are covered:

Physical Therapy;
Occupational Therapy;
Speech/Language Therapy.

Physical Therapy Services
Service Definition: Physical Therapy services are those that prevent physical disability through the evaluation and rehabilitation of physical therapeutic means such as: massage, manipulation, therapeutic exercise, cold heat, hydrotherapy, electrical stimulation, and light. Under a supervision of the licensed physical therapist. The recipient's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

Physical Therapy Services shall be included in the individual service plan only when it is necessary to prevent or delay the permanent physical impairment.

Physical Therapy Service Components:
1. Assessment
2. Therapeutic Exercises
3. Gait Training
4. Range of Motion
5. Maintenance Therapy Program

Occupational Therapy Services
Service Definition: The services of an occupational therapist would be necessary to assess the member's needs, to develop activities which are directed toward meeting the goals governing increased perceptual and cognitive function. A member's recovery and safety can be affected by perceptual and cognitive deficits. Deficits which impact the function of the planning, implementing, and supervision of therapeutic programs, including but not limited to those listed below, are:

a. Selecting and teaching task-oriented therapeutic activities designed to restore physical function.

b. Planning, implementing, and supervising therapeutic tasks and activities designed to restore sensory-integrative function.

c. Teaching compensatory techniques to improve the level of independence in the activities of daily living.

d. The designing, fabricating, and fitting of orthotic and self-help devices.

Vocational and prevocational assessment and training which are directed toward the restoration of function in the activities of daily living would not be directed toward the treatment of an illness or injury.

Occupational Therapy Services shall be included in the individual service plan only when it is necessary to prevent or delay institutionalization.

Occupational Therapy Service Components:
1. Evaluation
2. Independent Living/Daily Living Skills (ADL) Training
3. Muscle Re-education
4. Perceptual Motor Training
5. Fine Motor Coordination
6. Neurodevelopmental Treatment
7. Sensory Treatment
8. Orthotics/Splinting
9. Adaptive Equipment (fabrication and training)
10. Maintenance Therapy Program

Speech and Language Therapy Services

Service Definition: The skills of a speech-language pathologist are required for the assessment of a member's rehabilitative speech or motivation, clearing of confusion, or the remission of some other medical condition that previously contraindicated.

The services of a speech-language pathologist would be covered if they are needed as a result of an illness or injury and:

Speech-language pathology would be covered when the services can only be provided by a speech-language pathologist of attainment than prior to the initiation of the services.

The services of a speech-language pathologist to establish a hierarchy of speech-voice-language communication tasks an:

The services of a speech-language pathologist to train the member, family, or other caregivers to augment the speech-lan

The services of a speech-language pathologist to assist beneficiaries with aphasia in rehabilitation of speech and languag

Speech and Language Therapy Services shall be included in the individual service plan only when it is necessary to prev

Speech and Language Therapy Service Components:

1. Evaluation
2. Voice Disorders Treatments
3. Speech Articulation Disorders Treatments
4. Dysphagia Treatments
5. Language Disorders Treatments
6. Aural Rehabilitation

7. Maintenance Therapy Program

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

Amount, frequency and duration of service is prior authorized in accordance with service plan.

Service Delivery Method (check each that applies):

- [ ] Participant-directed as specified in Appendix E
- [x] Provider managed

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

- [ ] Legally Responsible Person
- [ ] Relative
Legal Guardian

Provider Specifications:

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Provider Type Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Home Care</td>
</tr>
<tr>
<td>Individual</td>
<td>Speech/Language Therapist</td>
</tr>
<tr>
<td>Individual</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Individual</td>
<td>Physical Therapist</td>
</tr>
</tbody>
</table>

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapy Services

Provider Category:
Agency

Provider Type:
Home Care

Provider Qualifications

License (specify):
63 O.S., Sec. 1-1961, et seq.

Certificate (specify):
None

Other Standard (specify):
• ADvantage Qualified Provider Certification [OAC 317:30-5-761]
• Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:
Oklahoma Department of Human Services

Frequency of Verification:
Prior to Enrollment and Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapy Services

Provider Category:
Individual

Provider Type:
Speech/Language Therapist

Provider Qualifications

License (specify):
59 O.S. Sec. 1601, et seq.

Certificate (specify):
None

Other Standard (specify):
• ADvantage Qualified Provider Certification [OAC 317:30-5-761]
• Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:
Oklahoma Department of Human Services

Frequency of Verification:
Prior to Enrollment and Annually
Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapy Services

Provider Category:
Individual

Provider Type:
Occupational Therapist

Provider Qualifications
License (specify):
59 O.S. Sec. 888.1, et seq.
Certificate (specify):
None

Other Standard (specify):
• ADvantage Qualified Provider Certification [OAC 317:30-5-761]
• Medicaid Provider Contract

Verification of Provider Qualifications
Entity Responsible for Verification:
Oklahoma Department of Human Services
Frequency of Verification:
Prior to Enrollment and Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapy Services

Provider Category:
Individual

Provider Type:
Physical Therapist

Provider Qualifications
License (specify):
59 O.S. Sec. 887.1, et seq.
Certificate (specify):
None

Other Standard (specify):
• ADvantage Qualified Provider Certification [OAC 317:30-5-761]
• Medicaid Provider Contract

Verification of Provider Qualifications
Entity Responsible for Verification:
Oklahoma Department of Human Services
Frequency of Verification:
Prior to Enrollment and 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.

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

Nineteen not-for-profit organizations provide case management. Of these, six are Area Agencies on Aging (AAAs) [four are Councils of Government AAAs and two are Area Agencies on Aging only]; three are Independent Living Centers; three are non-profits that primarily provide services for the elderly; two are social service organizations that serve persons with disabilities, two are home care agencies; one is an agency that specializes in services to persons having HIV/AIDS, one is a college of nursing and one is a Community Action Agency.

In addition, thirty-one other agencies are for-profit organizations. Of these, twenty-five are home care agencies.

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):

In accordance with Title 63 of Oklahoma Statutes, Sections 1-1950, an Oklahoma State Bureau of Investigation (OSBI) criminal background check must be performed prior to hiring persons providing Personal Care services. This is a state investigation. Any person convicted of any crimes described in the statute may not be hired to provide Personal Care services.

Proof of OSBI background check must be documented in the provider personnel record. Evaluation of documentation of OSBI background check prior to hire is a standard component of license review inspections by the Oklahoma Department of Health of Home Care Agencies and Adult Day Care Centers. In addition, evaluation of process to assure OSBI background check prior to hire is a standard component of ADvantage Program Provider certification process and evaluation of documentation of OSBI background check prior to hire is a standard component of ADvantage Provider Audits.

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):

In accordance with Title 63 of Oklahoma Statutes, Sections 1-1950, a provider of Personal Care services may have no pending notation related to abuse, neglect or exploitation as reported by the Nurse Aide Registry maintained by the Oklahoma State Department of Health.

In addition, in accordance with Title 56, of Oklahoma Statutes, Section 1025.2, a provider of direct care services may not be included on the Community Services Worker Registry maintained by the Oklahoma Department of Human Services.

Proof of both Nurse Aide Registry and Community Services Worker Registry checks must be documented in the provider personnel record. Evaluation of documentation of Nurse Aide Registry check prior to hire is a standard component of license review inspections by the Oklahoma Department of Health of Home Care Agencies and Adult Day Care Centers. In addition, evaluation of process to assure Nurse Aide Registry and Community Services Worker Registry checks prior to hire is a standard component of ADvantage Program Provider certification process and evaluation of documentation of Nurse Aide Registry and Community Services Worker Registry checks prior to hire are standard components of ADvantage Provider Audits.

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:

- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act.

- No. Home and community-based services under this waiver are not 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:

<table>
<thead>
<tr>
<th>Facility Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facility</td>
</tr>
<tr>
<td>Assisted Living Center</td>
</tr>
</tbody>
</table>

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.

The ADvantage Assisted Living Services benefit is available to individual service members who reside in Assisted Living Centers that are licensed by the Oklahoma State Department of Health and that have been certified by ADvantage program staff to offer a homelike physical environment with the following characteristics:

• Private occupancy apartments that are equipped with a lockable door, a bathroom, a means for controlling the temperature of the individual unit and a kitchenette, defined as a space containing a refrigerator, cooking appliance (microwave is acceptable) and adequate storage space for utensils and supplies. Units may be shared only if a request to do so is initiated by the member;
• Shared common space including a dining room, parlor or common activities center and a private administrative office that can be used to conduct confidential interviews; and
• Adequate protected outdoor space.

The ADvantage Assisted Living Service promotes service member choice, and to the greatest extent
possible, service member control. Members have control over their living space and choice of personal
amenities, furnishing and activities in their residence. The Assisted Living Service provider's
documented operating philosophy, including policies and procedures, must reflect and support the
principles and values associated with assisted living philosophy and approach to service delivery that
emphasizes member dignity, privacy, individuality, and independence. The ADvantage member must
have the freedom to control their schedule and activities.

Appendix C: Participant Services
C-2: Facility Specifications

Facility Type:
Nursing Facility

Waiver Service(s) Provided in Facility:

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Provided in Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td></td>
</tr>
<tr>
<td>Respite</td>
<td>✔</td>
</tr>
<tr>
<td>Adult Day Health</td>
<td></td>
</tr>
<tr>
<td>Advanced Supportive/Restorative Assistance</td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
</tr>
<tr>
<td>Environmental Accessibility Modifications</td>
<td></td>
</tr>
<tr>
<td>Personal Care</td>
<td></td>
</tr>
<tr>
<td>Therapy Services</td>
<td></td>
</tr>
<tr>
<td>Home-Delivered Meals</td>
<td></td>
</tr>
<tr>
<td>Specialized Medical Equipment and Supplies</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td></td>
</tr>
<tr>
<td>Personal Emergency Response Systems</td>
<td></td>
</tr>
<tr>
<td>Institution Transition Services</td>
<td></td>
</tr>
<tr>
<td>Consumer-Directed Personal Assistance Supports and Services</td>
<td></td>
</tr>
<tr>
<td>Assisted Living Services</td>
<td></td>
</tr>
<tr>
<td>Prescribed Drugs</td>
<td></td>
</tr>
</tbody>
</table>

Facility Capacity Limit:
N/A

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

<table>
<thead>
<tr>
<th>Scope of State Facility Standards</th>
<th>Topic Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission policies</td>
<td>✔</td>
</tr>
<tr>
<td>Physical environment</td>
<td>✔</td>
</tr>
<tr>
<td>Standard</td>
<td>Topic Addressed</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Sanitation</td>
<td>✔</td>
</tr>
<tr>
<td>Safety</td>
<td>✔</td>
</tr>
<tr>
<td>Staff : resident ratios</td>
<td>✔</td>
</tr>
<tr>
<td>Staff training and qualifications</td>
<td>✔</td>
</tr>
<tr>
<td>Staff supervision</td>
<td>✔</td>
</tr>
<tr>
<td>Resident rights</td>
<td>✔</td>
</tr>
<tr>
<td>Medication administration</td>
<td>✔</td>
</tr>
<tr>
<td>Use of restrictive interventions</td>
<td>✔</td>
</tr>
<tr>
<td>Incident reporting</td>
<td>✔</td>
</tr>
<tr>
<td>Provision of or arrangement for necessary health services</td>
<td>✔</td>
</tr>
</tbody>
</table>

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:

Assisted Living Center

Waiver Service(s) Provided in Facility:

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Provided in Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Adult Day Health</td>
<td></td>
</tr>
<tr>
<td>Advanced Supportive/Restorative Assistance</td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
</tr>
<tr>
<td>Environmental Accessibility Modifications</td>
<td></td>
</tr>
<tr>
<td>Personal Care</td>
<td></td>
</tr>
<tr>
<td>Therapy Services</td>
<td></td>
</tr>
<tr>
<td>Home-Delivered Meals</td>
<td></td>
</tr>
<tr>
<td>Specialized Medical Equipment and Supplies</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td></td>
</tr>
<tr>
<td>Personal Emergency Response Systems</td>
<td></td>
</tr>
<tr>
<td>Institution Transition Services</td>
<td></td>
</tr>
<tr>
<td>Consumer-Directed Personal Assistance Supports and Services</td>
<td></td>
</tr>
</tbody>
</table>
Waiver Service | Provided in Facility
--- | ---
Assisted Living Services | ✓
Prescribed Drugs | 

Facility Capacity Limit:
N/A

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Topic Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission policies</td>
<td>✓</td>
</tr>
<tr>
<td>Physical environment</td>
<td>✓</td>
</tr>
<tr>
<td>Sanitation</td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>✓</td>
</tr>
<tr>
<td>Staff : resident ratios</td>
<td></td>
</tr>
<tr>
<td>Staff training and qualifications</td>
<td>✓</td>
</tr>
<tr>
<td>Staff supervision</td>
<td>✓</td>
</tr>
<tr>
<td>Resident rights</td>
<td>✓</td>
</tr>
<tr>
<td>Medication administration</td>
<td>✓</td>
</tr>
<tr>
<td>Use of restrictive interventions</td>
<td>✓</td>
</tr>
<tr>
<td>Incident reporting</td>
<td>✓</td>
</tr>
<tr>
<td>Provision of or arrangement for necessary health services</td>
<td>✓</td>
</tr>
</tbody>
</table>

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:

Although Assisted Living licensure standards currently address many of these areas, the ADvantage certification requirements are more specific and/or more stringent to further safeguard the health and welfare of ADvantage members being served and/or to assure maintenance of a homelike living environment. Standards in addition to licensure standards that ADvantage waiver Assisted Living Providers will be required to meet are described below.

Admission policies
ADvantage-certified Assisted Living Centers (ALCs) are required to accept all eligible ADvantage members who choose to receive services through the ALC subject only to issues relating to:
1. unit availability;
2. incompatibility with tax credit funding requirements under which facility was built or is operating;
3. the compatibility of the participant with other residents; and
4. the center’s ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides.

Mild or moderate cognitive impairment of the applicant as documented by the UCAT is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate individuals who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the OKDHS ADvantage Administration (AA). The ALC must specify the number of units the provider is making available to serve ADvantage participants during the contract phase of provider enrollment.

Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage Case Manager, the member and/or member’s designated representative and the ALC in consultation with the AAU determines the appropriateness of placement.
The ALC is responsible for meeting the member’s needs for privacy, dignity, respect and freedom from coercion and restraint. The ALC shall optimize individual initiative, autonomy and independence in making life choices. The ALC shall facilitate individual choices regarding services and supports and who provides them. Inability to meet those needs will not be recognized as a reason for determining that an ADvantage member’s placement is inappropriate.

The ALC agrees to provide or arrange and coordinate all of the services listed in the description of assisted living center services in the regulations (310:663-3-3).

In addition, the ADvantage participating ALC agrees to provide or coordinate the following services:

• Provide an emergency call system for each participating ADvantage member;
• Provide up to three meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to members’ needs and choices; and provide members with 24 hours access to food by giving members control in selecting the foods they eat, allow members to store personal food in their rooms, preparing and eating food in their rooms and deciding when to eat; and
• Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control their personal resources and receive services in the community, to the same degree of access as individuals not receiving ADvantage services.

For ADvantage Assisted Living Services, assistance with “other personal needs” in the definition of “personal care” under OAC 310:663-1-2 includes assistance with toileting, grooming and transferring and the term “assistance” is clarified to mean hands-on help in addition to supervision.

The specific Assisted Living Services assistance to be provided including details of amount, duration and scope of each type of assistance are based upon the individual member’s assessed need for assistance. This detailed plan of service delivery is specified in the ALC’s service plan which is considered to be a more detailed documentation of the ADvantage comprehensive service plan. The ADvantage CM in cooperation with the ALC professional staff develops the service plan to meet member needs. As member needs change, the ALC’s provision of services must be adjusted to meet service needs and, as necessary, the service plan is amended by the CM consistent with the assessed, documented need for change in services or member need level for Assisted Living Services.

Definition of Inappropriate ALC Placement

Placement or continued placement of an ADvantage member in an ALC is inappropriate if any one or more of the following conditions exist:

• The member’s needs exceed the level of services the center provides. Documentation must support ALC multiple efforts to provide or arrange for the required services to accommodate participant needs;
• The member exhibits behavior or actions that repeatedly and substantially interferes with the rights or well being of other residents and the ALC has tried prudent and reasonable interventions. Documentation must support that ALC multiple attempted interventions to resolve behavior problems;
• The member has a medical condition that is complex, unstable or unpredictable and treatment cannot be appropriately developed and implemented in the assisted living environment. [Documentation must support that services required by the member are outside the amount, duration or scope allowed through assisted living services and that the ALC attempted to meet member needs by providing or obtaining appropriate care for the member within the scope of services permissible in an ALC.]; or
• The member fails to pay room and board charges.

The member may receive in ALC any ADvantage service documented as needed through assessment. However, other ADvantage services may not duplicate services provided by and the responsibility of the ALC. For example, nursing services for assessment and planning for ALC services and for intermittent nursing services as needed are part of the ALC service. Nursing services for wound care in an emergency situation would be a responsibility of the ALC nursing staff. However, ongoing wound care would have to be covered by the Medicare or Medicaid State Plan Home Health benefit.
Placement of the member in ALC is inappropriate if the member requires 24-hour nursing care/direct supervision or if the member requires specialized care/environment beyond what the ALC is licensed to provide such as dementia/Alzheimer care.

Termination of residency when inappropriately placed. If an ALC determines that a member is inappropriately placed, the assisted living center shall inform the member and/or the member’s representative, the member’s ADvantage CM and the AAU. The ALC shall develop a discharge plan in consultation with the member, the member’s support network and the ADvantage CM. The ALC and CM must ensure that the discharge plan includes strategies for providing increased services, when appropriate to minimize risk and meet the higher care needs of members awaiting a move out of the ALC, if reason for discharge is inability to meet member needs.

If voluntary termination of residency is not arranged, the ALC shall provide written notice to the member and to the member's representative, with a copy to the member’s ADvantage CM and the AAU, giving the member thirty (30) days written notice of the ALC’s intent to terminate the residency agreement and move the member to a more appropriate care provider. The thirty (30) day requirement shall not apply when:
1. emergency termination of the residency agreement is mandated by the member's immediate health needs; or
2. termination of the residency agreement is necessary for the physical safety of the member or other residents of the ALC.

The written notice of involuntary termination of residency for reasons of inappropriate placement shall include:
1. Full explanation of the reasons for the termination of residency;
2. The date of the notice;
3. The date notice was given to the member and the member’s representative, the AAU and the ADvantage case manager;
4. The date by which the member must leave the ALC; and,
5. Notification of appeal rights and process for submitting appeal of termination of Medicaid Assisted Living services.

Physical environment

(a) The ALC shall provide lockable doors on the entry door of each Unit and an attached lockable compartment within each member unit for valuables. Member residents shall have exclusive rights to their Units with lockable doors at the entrance of their individual and/or shared Unit except in the case of documented contraindication; Keys to their room may be held by the ALC appropriate staff as designated by the member's choice; Units may be shared only if a request to do so is initiated by the member resident; Members must be given the right to choose their roommate if they so desire. Unit entry is by permission of the member except in cases of emergency or pre-arrangement with the member;
(b) The member will have a legally enforceable agreement (lease) with the ALC. The member shall have the same responsibilities/protections from eviction as all tenants under landlord tenant law of the state, county, city or other designated entity.
(c) The ALC must provide each unit with a means for each member resident to control the temperature in the individual living unit through the use of a damper, register, thermostat, or other reasonable means that is under the control of the resident and that preserves resident privacy, independence and safety, provided that the Oklahoma State Department of Health may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.
(d) For ALCs built prior to July 2007, each ALC individual residential Unit shall have a minimum total living space (including closets and storage area) of 250 square feet; for ALCs built after June 2007, each ALC individual residential Unit shall have a minimum total living space (including closets and storage area) of 360 square feet.
(e) The ALC shall provide a private bathroom for each living Unit which shall be equipped with one lavatory, one toilet, and one bathtub or shower stall; If the member has special needs, the bathroom will be in compliance with ADA Accessibility Guidelines;
(f) The ALC shall provide at a minimum a kitchenette, defined as a space containing a refrigerator, cooking appliance (microwave is acceptable) and adequate storage space for utensils;
(g) The member is responsible for furnishing their rental unit; If a member is unable to supply basic
furnishings defined as a bed, dresser, nightstand, chairs, table, trash can and lamp, or if the member supplied furnishings pose a health or safety risk, the ADvantage CM in coordination with the ALC shall assist the member in obtaining basic furnishings for the unit. The member shall have the freedom to furnish and decorate their rental unit within the scope of the lease or residency agreement.
h) The ALC shall meet the requirements, of all applicable federal, state and local laws and regulations;
i) The ALC shall ensure the design of common areas accommodates the special needs of their resident population and that the residential unit accommodates the special needs of the individual in compliance with ADA Accessibility Guidelines;
j) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be: (1) proportionate to the number of residents, and (2) appropriate for the resident population;
k) The ALC shall provide appropriately monitored outdoor space for resident use.
l) The ALC must provide the member with the right to have visitors of their choosing at any time. Overnight visitation should be allowed but may be limited by the ALC to the extent to which a visitor can stay overnight.
m) The ALC must be physically accessible to member residents.

Sanitation

(a) The ALC shall maintain the facility including its individual units that is clean, safe, sanitary, insect and rodent free, odorless, and in good repair at all times.
b) The ALC shall maintain buildings and grounds in a good state of repair and in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws and codes.
c) The ALC stores clean laundry in a manner that prevents contamination and change linens at time intervals necessary to avoid health issues.
d) The ALC shall provide housekeeping in member units that maintains a safe, clean and sanitary environment.
e) The ALC shall have policies and procedures for member pets.

Health & Safety

(a) The ALC shall provide building security that protects residents from intruders with security measures appropriate to building design, environmental risk factors and the resident population;
b) The ALC shall respond immediately and appropriately to missing residents, accidents, medical emergencies or deaths.
c) The ALC shall have a plan in place to prevent, contain and report any diseases that are considered to be infectious and/or are listed as diseases that must be reported to the Oklahoma State Department of Health (OSDH).
d) The ALC must protect residents from abuse neglect or exploitation and respond promptly and effectively to allegations of abuse, neglect or exploitation.
e) The ALC shall ensure that fire safety requirements are met and shall provide services and facilities that accommodate the needs of residents to safely evacuate in the event of fires or other emergencies:
f) The ALC shall ensure that staff are trained to respond appropriately to emergencies.
g) The ALC shall adopt safe practices for the preparation and delivery of meals and all staff involved with meal preparation shall have attended a food service training program offered or approved by the OSDH; Meal offerings shall provide with a varied menu a balanced and adequate nutrition for residents. If a member has physician orders for special diet or nutritional monitoring, a registered dietitian shall monitor the member’s diet, health and nutritional status.
h) The ALC shall provide a 24-hour response to personal emergencies that is appropriate to the needs of the resident population.
i) The ALC shall provide safe transportation to and from ALC sponsored social/recreational outings.

Staff : resident ratios

(a) The ALC shall ensure that a sufficient number of trained staff shall be on duty, awake, and present at all times, 24 hours a day, 7 days a week, to meet the needs of residents and to carry out all the processes listed in the ALC’s written emergency and disaster preparedness plan for fires and other natural disasters.
b) The ALC shall ensure that staffing is sufficient to meet the needs of the ADvantage Program residents in accordance with each individual’s ADvantage Service Plan.
(c) The ALC shall have plans in place to address situations where there is a disruption to the ALC’s regular work force.

Staff training and qualifications

(a) The ALC shall ensure that all staff has qualifications consistent with their job responsibilities;
(b) All staff assisting in, or responsible for, food service shall have attended a food service training program offered or approved by the OSDH;
(c) The ALC shall provide staff orientation and ongoing training to develop and maintain the knowledge and skills of staff. All direct care and activity staff receive at least eight hours of orientation and initial training within the first month of their employment and at least four hours annually thereafter. If the ALC is licensed to provide dementia care (has a dementia unit) and commits to providing dementia care to ADvantage members, staff providing direct care on the ADvantage dementia unit must receive four additional hours of dementia specific training. Annual first aid and CPR certification do not count towards the four hours of annual training.

Staff supervision

(a) The ALC shall ensure delegation of tasks to non-licensed staff shall be consistent and in compliance with all applicable State regulations including, but not limited to, the Oklahoma Nurse Practice Act and the OSDH Nurse Aide Certification rules.
(b) The ALC shall ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietician monitors the member’s health and nutritional status.

Resident rights

(a) The ALC shall provide to each member and member’s representative, at the time of admission, a copy of the resident statutory rights listed in O.S. 63-1-1918 amended to include additional rights and clarification of rights as listed in the ADvantage Consumer Assurances. Copies of resident rights and resident complaints procedures shall be posted in an easily accessible, conspicuous place in the facility. A copy of the complaint procedure shall also be given to each resident, the resident’s representative, or where appropriate, the court appointed guardian. The facility shall ensure that its staff is familiar with, and observes, the resident rights.
(b) The ALC shall provide to each member and member’s representative, at the time of admission, information about Medicaid grievance/appeal rights including a description of the process for submitting a grievance/appeal of any decision that decreases Medicaid services to the member.

Incident reporting

(a) The ALC shall maintain a record of incidents that occur and report incidents to the member’s ADvantage CM, to the ADvantage Program AA and to other entities as required by law or regulation.
(b) Incidents requiring report by licensed Assisted Living Centers are those defined by the Oklahoma State Department of Health (OSDH) in OAC 310:663-19-1.

Provision of or arrangement for necessary health services

(a) The ALC shall arrange or coordinate transportation for members to and from medical appointments.
(b) The ALC shall provide or coordinate with the member and the member’s ADvantage CM for delivery of necessary health services.

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.*

Services and Supports Provided by a Legally Responsible Individual

In accordance with Oklahoma Administrative Code 317:30-5-761, for a legally responsible spouse or guardian of an adult member to be paid under the 1915(c) ADvantage Medicaid waiver, the personal care/assistance service must meet all of the following authorization criteria and monitoring provisions.

Authorization for a spouse or guardian to be the care provider for a member’s personal care/assistance service may occur only under the following conditions:

- The member is offered a choice of providers and documentation demonstrates that:
  - Either no other provider is available; or,
  - Available providers are unable to provide necessary care to the member, or
  - The needs of the member are so extensive that the legally responsible spouse or guardian who provides the care is prohibited from working outside the home due to the member’s need for care.

The service must:

- meet the definition of a service/support as outlined in the federally approved waiver document;
- be necessary to avoid institutionalization;
- be a service/support that is specified in the individual service plan;
- be provided by a spouse or guardian who meets the provider qualifications and training standards specified in the waiver for that service;
- be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the State Medicaid Agency for the payment of personal care or personal assistance services;
- NOT duplicate or replace assistance and/or care that the spouse or guardian would ordinarily perform or is responsible to perform.

If any of the following criteria are met, assistance or care provided by the spouse or guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or guardian:

- Spouse or guardian has resigned from full-time/part-time employment to provide care for the member, or
- Spouse or guardian has reduced employment from full-time to part-time to provide care for the member, or
- Spouse or guardian has taken a leave of absence without pay to provide care for the member, or
- Spouse or guardian provides assistance/care for the member thirty-five or more hours per week without pay and the member has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the member.

When under the aforementioned conditions, a legally responsible spouse or guardian provides personal care/assistance services to a waiver participant, special forms and procedures are used by the Case Manager to document this occurrence including forwarding a copy of documentation forms to the AA.

The spouse or guardian who is a service provider must comply with the following:
• continue non-reimbursed family responsibilities of primary caregiver and emergency backup caregiver;
• not provide more than 40 hours of reimbursed services in a seven day period;
• make planned work schedules available two weeks in advance, and variations to the schedule must be noted and supplied to the fiscal agent when billing;
• maintain and submit time sheets and other required documentation for hours paid;
• the spouse or guardian as the member’s care provider must be documented in the service plan.

Monitoring Requirements:

In addition to Case Management monitoring and reporting activities required for all waiver services, the state is obligated to the following additional monitoring requirements when a member elects to use a legally responsible spouse or guardian as a paid service provider:
• at least quarterly reviews by the OKDHS ADvantage Administration of expenditures, and the health, safety, and welfare status of the individual recipient;
• OKDHS ADvantage Administration face-to-face visits with the recipient on at least a semi annual basis; monthly reviews by the OKDHS ADvantage Administration of hours billed for spouse or guardian provided care.

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.

☐ 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.

See C-2-d regarding limitations on provision of services by legal guardians or other legally responsible persons and oversight of such provision of services.

Personal Care services are intended to supplement and support existing informal care and the use of informal supports as Personal Care Attendants may jeopardize the informal support system. In the ADvantage Program the relevant issue is not whether the person being hired to provide personal care/assistance services is a relative or not as much as whether the person being hired is already a part of the informal support system providing services informally and without compensation. Consequently, a provider agency may only employ member relatives or other persons who are currently providing services without compensation to provide personal care or similar services with the written agreement of the interdisciplinary team.

Prior to agreeing to permit employment of relatives or other persons who are already providing informal supports, the interdisciplinary team takes the following into consideration:
• The member has been offered a choice of providers and documentation demonstrates that:
  o Either no other provider is available; or,
  o Available providers are unable to provide necessary care to the member, or
  o The needs of the member are so extensive that the relative or an informal support that provides the care is prohibited from working outside the home due to the member's need for care; and,
  o In the team’s judgment, employment of the relative/informal provider as a paid provider will not overburden the individual so employed and ultimately be destructive to maintaining member supports.

When under the aforementioned conditions, a relative or other person providing informal supports is hired to provide personal care/assistance services to a waiver participant, special forms and procedures are used by the Case Manager to document this occurrence including forwarding a copy of documentation forms to the AA.
Controls employed to ensure that payments are made only for services rendered are the same as applied to all providers:
• Units are authorized on the service plan consistent with tasks required to meet member needs;
• Time-sheet documentation of service delivery is required of all direct care providers;
Provider audits review documentation for compliance of delivery of services to authorization.

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:

Throughout the year, any willing provider requesting to become an ADvantage provider submits their contact information to the AAU Contracts Department. Providers requesting to contract to provide ADvantage Case Management, Home Care, Assisted Living or Hospice services are advised that they will be contacted when the next New Provider meeting will be held. All other Provider types requesting to contract to provide ADvantage services, are mailed Contracts and all other necessary contractual documents to be read, completed, signed, and returned to the AAU for approval.

Based on the number of Case Management, Home Care, Assisted Living and Hospice providers who express an interest, Provider meetings will be held throughout the year to inform potential providers of the performance standards and guidelines required of those providing services to members in the ADvantage Program. At minimum, a public meeting will be held annually to advise potential new providers about the ADvantage Program. All potential Providers will receive an application, copies of the contractual documents, and submission timeframes to become an ADvantage provider.

The certification process involves a review of general and administrative, financial, and programmatic components of the provider application to determine the potential provider’s capacity and capability to provide ADvantage services that meet or exceed minimum standards. The certification process results in the determination of a potential provider’s qualifications to become an ADvantage Provider.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.
Performance Measure:
Number and Percent of providers that initially met licensing standards and requirements prior to furnishing waiver services. Numerator: Number of new licensed/certified Providers that met standards prior to furnishing waiver services. Denominator: Total number of new licensed/certified ADvantage providers.

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

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Performance Measure:
Number and Percentage of providers that continue to meet licensing standards and requirements after initial enrollment as a licensed and/or certified provider. Numerator: Number of licensed and/or certified Providers (by type) that continue to meet standards to provide services. Denominator: All licensed and/or certified providers by type.

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

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**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 non-licensed/non-certified providers who initially met waiver qualifications prior to providing services. Numerator: Number of non-licensed/non-certified Providers (by Type) that met standards prior to furnishing waiver services. Denominator: Total new non-licensed / non-certified providers (by Type).

**Data Source** (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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Performance Measure:
Number and Percentage of non-licensed/non-certified providers that continue to meet standards and requirements after initial enrollment

Numerator: Number of Non-licensed/non-certified Providers that continue to meet standards after initial enrollment...
enrollment year. Denominator: Total non-licensed / non-certified providers enrolled after initial enrollment year.

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

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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:
Number and Percentage of Case Managers that met training requirements as specified in the waiver. Numerator: Number of Case Managers that met training requirements as specified in waiver Denominator: Total Number of Case Managers

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

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#### 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.

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#### b. Methods for Remediation/Fixing Individual Problems

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

OHCA and OKDHS 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. The OHCA dedicated waiver staff will maintain administrative authority through the use of an electronic database designed for storing information received related to problems identified and resolutions of these matters. The OHCA Director of Waiver Administration and Development will be directly responsible for mediating any individual problems pertaining to administrative authority. The Director of Waiver Administration and Development will work with the designated OKDHS Point of Contact to resolve any problems in a timely manner. Problems requiring system change or additional staff will be addressed through the ADvantage Quality Management Strategies Council (QMSC) which may
form workgroups involving appropriate personnel to resolve issues more timely and effectively or to initiate systemic changes to address re-occurring issues/performance failures. These problems and resolutions will also be reported in the LTCQIC meetings.

Individual problems may be discovered during monitoring activities by the State or by any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring are described in each performance measure of this appendix.

The options for remediation of Qualified Provider assurances performance failures are listed below:

Remediation for Qualified Provider Assurances:

- Number and Percentage of provider agencies that initially met licensing standards and requirements prior to furnishing waiver services.
- Number and Percentage of provider agencies that continue to meet licensing standards and requirements after initial enrollment as a licensed and/or certified provider.
- Number and Percentage of non-licensed/non-certified providers who initially meet waiver qualifications.
- Number and Percentage of non-licensed/non-certified providers that continue to meet standards and requirements after initial enrollment.
- Number and Percentage of Case Managers that met training requirements as specified in the waiver.

OKDHS Provider Contracts staff monitor that certifications of providers as qualified are performed in accordance with waiver and Medicaid Agency policy. If any instances are found in which a provider (either licensed or non-licensed/non-certified) furnished ADvantage services prior to meeting all standards and requirements, or in which an enrolled provider (either licensed or non-licensed/non-certified) failed to continue to meet standards and requirements after initial enrollment, or in which any active ADvantage Case Manager failed to meet training requirements, the OKDHS ADvantage Programs Assistant Administrator for Provider/Client Relations contacts directly for resolution the Provider and appropriate OKDHS staff and, if deemed necessary, the Programs Assistant Administrator for Provider/Client Relations will be required to submit, within five working days of request, a corrective action plan to the Programs Administrator of the ADvantage Administration Unit.

If as part of remediation, a provider corrective action plan is required, the plan will detail the steps to be taken to correct current and prevent future performance failures along with the timeframe, not to exceed 30 days, for implementation of the corrective actions. Depending on the nature of non-compliance, providers may retain enrollment status if they are able to come into compliance with requirements within the 30-day period of the corrective action plan. During periods of corrective action for failure to meet standards, referrals to the provider are discontinued. Providers that do not meet qualified provider requirements will be disenrolled. Reimbursements to a provider for services may be recouped if the provider is found to have been out of compliance with qualified provider requirements at time of service delivery. Any performance failures, or remediation corrective actions, that result in a change of service providers for members will be referred to the EOCC for appropriate follow-up to safeguard the health and safety of members affected.

Quarterly, OKDHS will provide reports of remediation and corrective action plans (if any) to the ADvantage QMSC and to the OHCA Director of Waiver Administration and Development.

ii. Remediation Data Aggregation

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

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https://wms-mmdl.cdsvd.com/WMS/faces/protected/35/print/PrintSelector.jsp 1/20/2015
c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☐ No
☐ Yes

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

Appendix C: Participant Services
C-3: Waiver Services Specifications

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

Appendix C: Participant Services
C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

Furnish the information specified above.

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

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

Furnish the information specified above.

Other Type of Limit. The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings 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.

Currently, ADvantage members’ residential settings comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5). Members are afforded the freedom of choice when choosing a residential setting. Members can choose among setting options including non-disability specific settings and an option for private unit in a residential setting. Residential settings are integrated and support full access to the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving HCB services. The member’s residential setting ensures the right to privacy, dignity and respect and freedom from coercion and restraint. Additionally, the setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact. ADvantage members are entitled to individual choice regarding services and supports, and who provides them.

The State assures that Assisted Living Centers (Provider owned or controlled HCB settings) comply with federal HCB Setting requirements. If an ADvantage member should choose to receive home and community based services in a provider owned or controlled setting where the provider is paid a single rate to provide bundled services, the member chooses the provider.

If members decide to choose Assisted Living Centers, they will have a lease or other legally enforceable agreement providing similar protections. ADvantage members will have privacy in their unit including lockable doors, choice of roommates (if member chooses to share a unit) and freedom to furnish or decorate the unit within the lease or other agreement. Members will have the freedom to control their own schedule including visitation and access to food at any time. Additionally all provider owned or controlled HCB settings are physically accessible.

Adult Day Health Centers (non-residential setting) under this waiver also comply with federal HCB Setting requirements as listed above. ADvantage members have the freedom to choose a non-residential setting to receive their waiver services from the setting options identified and documented in the person-centered service plan and are based on the individual's needs, preferences. The State will review person-centered service plans to ensure that the plan reflects the setting in which the individual resides in was chosen by the individual. Through this verification process the State ensures that the setting chosen by the individual is integrated in, and supports full access of members to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving HCB services.

The State assures that all residential and non-residential settings will comply with federal HCB setting requirements at 42 CFR 441.301(c)(4)-(5) at the time of submission and ongoing.
Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
ADvantage Participant-Centered Service 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:

- [ ] 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:

Providers of HCBS for the participant, or those who have an interest in or are employed by a provider of HCBS for the participant must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

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

All participants are informed that they have freedom of choice of providers and that they may change providers at any time.

Service plans are reviewed by the OKDHS ADvantage Administration (AA) prior to approval both with regard to the plan services meeting assessed needs and with regard to service units appearing to be appropriate to meet assessed needs.

The AA maintains a Resource Center/Escalated Issues unit to register member, family or provider complaints.
and problems or incidents. The Resource Center/Escalated Issues unit is accessed via a toll-free 800 number. As part of orientation, each member is provided information about Resource Center and the 800 number by the Case Manager. The Resource Center is supported by a database system to track complaints/incidents, to support AA assignment of Consumer Advocate staff to investigate, to track resolution process and record actions and resolution for each complaint or incident.

Quality of service delivery performance of all providers is monitored by OKDHS (Provider Audits) and by the AA (Resource Center/Escalated Issues and Provider?). Individualized reports for provider complaint/incident are produced for complaint/incident tracking. These reports are utilized to identify patterns of incident or problem types requiring attention or patterns of complaints/incidents that may alert AA of potential quality problems with individual providers.

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.

One of the foundational modules in the ADvantage Case Management Training is Interdisciplinary Teams (IDT). This module is designed to educate case managers about the IDT approach to service planning and to emphasize the philosophy of seeing the “whole” person through a variety of perspectives. This module educates case managers that members, and or member representatives, are expected to be actively engaged in the initial and ongoing IDT process, service planning process and service plan monitoring process. In addition, this module presents the critical step of talking with the member before each IDT in order to identify who the member would like to invite to the team table.

Case Managers have specialized skills and competencies to perform, at minimum, five core functions. The core functions form an on-going and dynamic process. Case Management core functions are:

1. **Comprehensive Assessment:** Transition Coordination/Case management requires a comprehensive, systematic, standardized, and multi-dimensional assessment of the member’s functional and cognitive capacity and limitations, need for services, strengths, abilities, supports and resources.
2. **Planning:** Planning is a resource allocation process where a service prescription is developed for a member that defines the types of services needed and the amount, frequency and duration of service delivery to meet assessed needs.
3. **Implementation:** Plan implementation is a process of contracting both formal and informal providers to arrange for services outlined in the plan.
4. **Monitoring:** “the continuing contact the Case Manager has with providers and members to ensure that services are provided in accordance with the service plan and to ascertain whether these services continue to meet the member’s needs.” (Schneider & Weiss, 1982)
5. **Reassessment:** “scheduled or event-precipitated examination of the member’s situation and functioning to identify changes which occurred since the initial or most recent assessment and to measure progress toward the desired outcomes outlined in the service plan.” (Schneider & Weiss, 1982)

Case Managers must perform the core functions previously described and also adhere to HCBS long-term supports and services case management principles. Performing the core functions and following the principles below assures continuity and quality of long-term care case management and services and supports to the member.

1) **Principle #1 Case Management is Participant Centered:** Case Management is a Participant-centered service that respects Participants’ rights, values and preferences.

2) **Principle #2 Case Management Coordinates ALL Assistance:** Case Management coordinates all and any type of assistance to meet identified Participant needs including those related to the transition process and those related to community living.

3) **Principle #3 Case Management requires knowledge, skills & competencies:** To perform well, case managers require specialized clinical skills, knowledge, and personal characteristics and competencies.

4) **Principle #4 Case Management promotes quality:** Case management promotes the quality of services provided.
5) Principle #5 Case Management is goal oriented: Case management is forward looking and makes plans to reach member defined goals based on today’s indicators.

6) Principle #6 Case Management uses resources efficiently: In the prescription of services to meet, but not to exceed, assessed need and to efficiently coordinate services, case management is a cost-effective service.

During this module, case managers are given a self-evaluation tool to evaluate their IDT facilitation performance. The tool emphasizes supporting the member to speak for him/herself and to support the member to be actively engaged in the process. Case managers are encouraged to implement the tool after their first few ADvantage member IDT experiences.

A Participant-centered planning approach guides the service plan development process. The Case Manager (CM) explains the process to the ADvantage member and others that the member desires to participate in service planning.

The CM provides support to the member in this Participant-centered planning process, including providing information about qualified providers of ADvantage services and information on community resources for informal and non-ADvantage formal services of interest to the member.

In the planning process, the CM helps the member define support needs, service goals and service preferences including access to and use of generic community resources. The CM assists the member in translating the assessment of member needs and preferences into an individually tailored, personalized service plan.

The AA shall ensure that a written Service Plan will be developed for each eligible individual that wants to participate in this waiver. Once an individual’s eligibility is determined, the individual, his or her family members, legal guardians or other representatives will convene a service planning team for the purpose of developing the service plan. Members of the service plan team are selected by the member and may include the individual, his or her family members, his or her legal guardians, advocates, friends and support personnel from other provider agencies.

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):

In accordance with OAC 317:35-17-14, Case management services involve ongoing assessment, service planning and implementation, service monitoring and evaluation, member advocacy, and discharge planning.

(1) Within one working day of receipt of an ADvantage referral from the ADvantage Administration (AA), the case management supervisor assigns a case manager to the member. Upon assignment of member, the Case Manager contacts the member to arrange to meet in the member's home or at another location chosen by the member and at a time convenient for the member. After being assigned an ADvantage member, the case manager makes a home visit to review the ADvantage program (its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, AA and OKDHS in the program), and review, update and complete the UCAT assessment, and to discuss service needs and ADvantage service providers. The Case Manager notifies in writing the member's UCAT identified primary physician that the member has been determined eligible to receive ADvantage services. The notification is via a preprint form that contains the member's signed permission to release this health information and requests physician's office verification of primary and secondary diagnoses and diagnoses code obtained from the UCAT.

(2) Within 14 calendar days of the receipt of an ADvantage referral, the case manager completes and submits to the AA an individualized care plan and service plan for the member, signed by the member and the case management supervisor. The case manager completes and submits to the AA the annual reassessment service plan documents no
sooner than 60 days before the existing service plan end date but sufficiently in advance of the end date to be received by the AA at least 30 calendar days before the end date of the existing service plan. Within 14 calendar days of receipt of a Service Plan Review Request (SPR) from the AA, the Case Manager provides corrected care plan and service plan documentation. Within five calendar days of assessed need, the case manager completes and submits a service plan addendum to the AA to amend current services on the care plan and service plan. The care plan and service plan are based on the member's service needs identified by the UCAT, Part III. The service plan incorporates, to the extent possible, non-waiver services to meet member needs. Non-waiver community-based services include, but are not limited to, Medicare, Medicaid State Plan, Veterans services, United Way and/or other local community furnished services. For the ADvantage service portion of the service plan, the plan includes only those ADvantage services required to sustain and/or promote the health and welfare of the member. The case manager uses an interdisciplinary team (IDT) planning approach for care plan and service plan development. If in-home care is the primary service, the IDT includes, at a minimum, the member, a nurse from the ADvantage in-home care provider chosen by the member, and the case manager. Otherwise, the member and case manager constitute a minimum IDT.

(3) The case manager identifies long-term goals, challenges to meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The case manager identifies services, service provider, funding source, units and frequency of service and service cost, cost by funding source and total cost for ADvantage services. The member signs and indicates review/agreement with the care plan and service plan by indicating acceptance or non-acceptance of the plans. The member, the member's legal guardian or legally authorized representative shall sign the service plan in the presence of the case manager. The signatures of two witnesses are required when the member signs with a mark. If the member refuses to cooperate in development of the service plan, or, if the member refuses to sign the service plan, the case management agency refers the case to the AA for resolution. In addition, based on the UCAT and/or case progress notes that document chronic uncooperative or disruptive behaviors, the LTC nurse or AA may identify members that require AA intervention.

(4) The case manager submits the care plan and service plan to the case management supervisor for review. The case management supervisor documents the review/approval of the plans within two working days of receipt from the case manager or returns the plans to the case manager with notations of errors, problems, and concerns to be addressed. The case manager re-submits the corrected care plan and service plan to the case management supervisor within two working days. The case management supervisor returns the approved care plan and service plan to the case manager. Within one working day of receiving supervisory approval, the case manager forwards, via postal mail, a legible copy of the care plan and service plan to the AA. Case managers are responsible for retaining all original documents for the member's file at the agency. Only priority service needs and supporting documentation may be faxed to the AA with the word, "PRIORITY" being clearly indicated and the justification attached. "Priority" service needs are defined as services needing immediate authorization to protect the health and welfare of the member and/or avoid premature admission to the nursing facility. Corrections to service conditions set by the AA are not considered to be a priority unless the health and welfare of the member would otherwise be immediately jeopardized and/or the member would otherwise require premature admission to a nursing facility.

(5) Within one working day of notification of care plan and service plan authorization, the case manager communicates with the service plan providers and with the member to facilitate service plan implementation. Within one working day of receipt of a copy or the computer-generated authorized service plan from the AA, the case manager sends (by mail or fax) copies of the authorized service plan or computer-generated copies to providers. Within five working days of notification of an initial or new service plan authorization, the case manager visits the member, gives the member a copy of the service plan or computer-generated copy of the service plan and evaluates the progress of the service plan implementation. The case manager evaluates service plan implementation on the following minimum schedule:

(A) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and
(B) monthly after the initial 30 day follow-up evaluation date.

Change in service plan. The process for initiating a change in the service plan follows:
A member or family member may become aware of a change in member needs and may initiate a request for a change in the service plan by contacting the case manager. In addition, a service provider may initiate the process for an increase or decrease in service to the member's service plan. The requested changes and justification for them are documented by the service provider and, if initiated by a direct care provider, submitted to the member's case manager. If in agreement, the case manager requests the service changes on a care plan and service plan amendment submitted to the AA. The AA approves or denies the care plan and service plan changes within five working days of receipt of the plan.
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.

OKDHS ADVantage Administration (AA) conducts case management training for all case managers and provides basic knowledge and tools to enable case managers to assess appropriately and develop Service Plans which adequately address issues of risk and risk mitigation.

During service plan development, the member’s case manager assesses the member’s risks and develops a service plan that addresses the risks as well as the back-up plans for management of risks. In this process, the Case Manager works with the member and provider to ensure that an effective back-up plan is in place. Such back-up plans may utilize various combinations of formal supports from multiple providers to ensure continuity of services. In addition the Case Manager educates the member regarding potential risks and options to address risk to obtain member informed choice of options. The Case Manager provides advocacy support to the member in development of service delivery to honor member preference for level of risk acceptance and for risk mitigation measures built into the service plan including the particular backup services selected and the manner in which backup services are delivered. Case Manager support and advocacy for individual member preference occurs during service plan development and, thereafter, as needed.

Service Plans are submitted to OKDHS ADVantage Administration (AA) for review and authorization. The Service Plan Authorization team uses defined processes to further assess and address risk factors. Service Plan Analysts complete a detailed non-clinical review of every new Service Plan and Reassessment Service Plan using the following high risk indicators:

- UCAT Mental Status Questionnaire (MSQ) score over 18, without evidence of 24 hour supervision/support.
- Lives alone with MSQ over 12.
- History of falls without evidence of fall prevention plan in goals.
- Evidence of wounds.
- Medication management issues.
- Ventilator dependent.
- APS involvement.
- Unable to transfer or evacuate the home independently.
- Unable to ambulate without assistance and is left alone for periods of time.
- Unable to use telephone or PERS (Personal Emergency Response System) device.
- Need for 24 hour support is documented but is not provided per Service Plan.
- Severe mental health conditions / risk of harm to self or others.
- Environmental hazards are identified by assessor.
- Request for personal care and / or ASR hours in excess of 20 per week.
- No Backup Plan.

Service Plans with any of the above indicators are forwarded to the Service Plan Authorization Supervisor, or clinical review team RN, for additional review. Plans are then reviewed in detail for addressing of identified indicators per Service Plan Goals. Outcome of the reviews are as follows:

- Service Plan is determined to have addressed all identified risk factors, no further action is taken.
- Service Plan has not addressed risk factors; condition is placed on case management requesting documentation which addresses issues; the case management provider must submit revised documentation which addresses issues in order for the service plan to be approved.
- Identified issues are significant enough to warrant escalation to the Clinical Review Team and/or the Escalated Issues Team. An RN Consumer Advocate or an Escalated Issues Team Member investigates the issue by contacting the case manager, collaboration then occurs for appropriate addressing and / or resolution of the issue(s).

When members are supported in their own private residence or other settings where staff might not be continuously available, at a minimum, back-up plans are developed for the following services:

1. Direct service worker
2. Critical health or supportive services
3. Equipment repair or replacement.
For each back-up plan, the provider agency that is to furnish staff support on an on-call basis as necessary is the first tier of back-up support. For the CD-PASS member, this back-up support may be an identified alternate care provider or an agency provider. As a secondary tier, the member's informal supports may give their consent to provide the critical service in the event it is needed for the member. The third tier back-up support for members is the member's Case Manager who may arrange temporary alternate community services or supports. For extreme emergencies that rise to the fourth tier level, the 9-1-1 emergency statewide call system is to be used.

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.

During assessment for LOC medical eligibility, the OKDHS LTC nurse informs the member and family of agencies certified to deliver ADvantage Case Management and in-home care services in the local area to obtain the member's primary and secondary informed choices. The LTC nurse documents the names of the chosen agencies and the agreement (by dated signature) of the member to receive services provided by the agencies. If the member or his/her legal representative declines to make a provider choice, the OKDHS nurse documents the declination to make a selection on the Freedom of Choice form. If the Member has not made a selection on the Freedom of Choice form for either Case Management, Home Care or both, the AA initiates a rotating system to select an agency (Case Management, Home Care or both) for the member from a list of ADvantage certified/contracted case management and in-home care agencies providing services in the area in which the member resides. With referral to the Case Management Agency, The AA provides to the Case Management Agency the name of the Home Care agency selected by the member or identified through the rotating system, if member declined to choose.

After completing the in-home assessment, as part of the planning process, the Case Manager discusses service options for meeting member needs. The list of qualified service providers in the local area are reviewed with the member and the member, in consultation with the CM, selects a provider to deliver each service.

As a regular function of monitoring the member, the Case Manager consults with the member about satisfaction with services and service providers. The Case Manager furnishes information whenever the member requests information about available service providers. Members may also look on the ADvantage web page for information about waiver providers, querying by provider type and by the counties served.

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):

Authorization of service plans and amendments to service plans: The OKDHS ADvantage Administration (AA) authorizes the individual service plan and all service plan amendments for each ADvantage member using protocol and criteria established by the Medicaid Agency. The AA Service Plan Authorization unit (SPA) reviews/authorizes the initial service plan for each member enrolled in ADvantage. In addition, the AA/SPA at a minimum of annually or more frequently if a change in member health/condition occurs, reviews/authorizes a new service plan or amendments to the existing service plan based upon member assessed need submitted by the member’s Case Manager.

Service Plans with any of the risk factors identified in Appendix D-1 are forwarded to the Service Plan Authorization Supervisor, or clinical review team RN, for additional review. Plans are then reviewed in detail for addressing of identified indicators per Service Plan Goals. Outcome of the reviews are as follows:

• Service Plan is determined to have addressed all identified risk factors, no further action is taken.
• Service Plan has not addressed risk factors; condition is placed on case management requesting documentation which addresses issues; the case management provider must submit revised documentation which addresses issues in order for the service plan to be approved.
• Identified issues are significant enough to warrant escalation to the Clinical Review Team and/or the Escalated Issues Team. An RN Consumer Advocate or an Escalated Issues Team Member investigates the issue by contacting the case manager, collaboration then occurs for appropriate addressing and/or resolution of the issue(s).

When the AA/SPA verifies member ADvantage eligibility, plan cost effectiveness, that service providers are
ADvantage authorized and Medicaid contracted, that the delivery of ADvantage services are consistent with the member’s assessed need and that all identified risk factors have been addressed, the service plan is authorized.

AA Service Plan Authorization unit staff document authorized service plans on the Waiver Management Information System (WMIS). Prior Authorizations are generated for individual services from WMIS and posted on the MMIS.

All waiver service plans are subject to review and approval by both OKDHS/AAU (the operating agency) and the Waiver Administration and Development department of the OHCA (the Medicaid agency).

OHCA does not review and approve all service plans prior to implementation; however, all are subject to the Medicaid Agency's approval. OKDHS/AAU does review a sampling of member charts which includes the service plan. Reviewed service plans 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 service plans 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. Provider audits occur on average; one to two times per month, with several plans of care reviewed during each audit.

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
- [x] Operating agency
- [x] 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.
A certified ADvantage Case Manager employed by a qualified ADvantage Case Management provider agency is responsible for monitoring the implementation of the service plan and the participant’s health and welfare. The Case Manager monitors that services are provided in accordance with the service plan, that the member is accessing waiver and non-waiver services as identified in the service plan, that services meet members' needs and that the members’ back-up plan is operational, if needed. This periodic monitoring of the implementation of the service plan ensures that waiver services meet the member's need and achieve their intended outcomes. The monitoring is also conducted to identify any problems related to the member's health and welfare that may require action.

The case manager, during all monitoring activities, monitors health and safety, progress toward Service Plan goals, member satisfaction with services, identifies any major life changes and continues to assess for level of care and program appropriateness.

Within five working days of notification of an initial or new service plan authorization, the Case Manager visits the member in his/her home and evaluates the progress of the service plan implementation. Thereafter, the Case Manager evaluates service plan implementation on the following minimum schedule:

(A) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and
(B) Monthly after the initial 30 day follow-up evaluation date.

The monthly monitoring may be conducted by phone only if the member demonstrates cognitive and communication ability to provide valid information.

At a minimum, quarterly in-home Face-to-Face visits with the member are required.

When a member is un-staffed, the case manager contacts the member and Home Care Agency weekly to provide more frequent monitoring of health and safety, major life changes, possible need to change providers; and to monitor the recruiting activities of the provider to determine when and if a change of provider is indicated. Weekly phone call monitoring occurs until member is staffed.

The case management agency is require to have procedures in place to identify high risk members and situations that threaten the health and safety of the member and implements risk management mechanisms to manage all high risk situations of ADvantage members. This standard is reflected through the agency’s commitment of sufficient implementation resources, supervision activities, documentation practices and management reports.

Minimum Components of Agency Policies and Procedures

A. The case management agency defines high risk and sets criteria for monitoring high risk members.

B. The case manager develops an individualized High Risk Plan in conjunction with the member’s Service Plan.

C. The case management agency provides heightened supervisory and administrative scrutiny of high risk monitoring activities.

The State ensures that the case management agencies provide for prompt follow-up and remediation of identified problems. The case manager addresses any problem identified with the service plan implementation. Problems with service delivery or with change in service need discovered through monitoring are addressed by the Case Manager through updated assessment and development and submission of service plan amendments to address discovered unmet needs of the member. Additionally, depending on the nature of the problem discovered, the Case Manager engages APS and/or the AA Escalated Issues Unit for assistance in remediation.

AA Escalated Issues Unit staff initiates follow up and remediation of any identified problems related to service plan implementation.

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:
Providers of HCBS for the participant, or those who have an interest in or are employed by a provider of HCBS for the participant must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

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

1. All participants are informed that they have freedom of choice of providers and that they may change providers at any time.

2. Service plans are reviewed by the OKDHS ADvantage Administration (AA) prior to approval both with regard to the plan services meeting assessed needs and with regard to service units appearing to be appropriate to meet assessed needs.

3. ADvantage Program certification Conditions of Provider Participation (COPP) requires each Case Management provider to provide an accessible means for members to register complaints and a process for provider follow-up action to resolve complaints and address member identified problems. The system must track and report on provider performance and member satisfaction with services and provide a process that the provider uses to regularly assess and develop interventions to try to improve provider performance. ADvantage Program provider audits assess provider compliance with COPP and with provider service standards.

5. At a systems level, the AA maintains a Resource Center/Escalated Issues unit to register member, member family or provider/case manager complaints, problems or incidents. The Resource Center/Escalated Issues unit is accessed via a toll-free 800 number. As part of orientation, each member is provided information about Resource Center and the 800 number by the Case Manager. The Resource Center/Escalated Issues unit is supported by a database system to track complaints/incidents, to support AA assignment of Consumer Advocate staff to investigate, to track resolution process and record actions and resolution for each complaint or incident.

6. Quality of service delivery performance of all providers is monitored by OKDHS (Provider Audits) and by the AA (Resource Center/Escalated Issues unit and Provider?). Individualized reports for provider complaint/incident are produced for complaint/incident tracking by Case Management providers. These reports are utilized to identify patterns of incident or problem types requiring attention or patterns of complaints/incidents that may alert the AA of potential quality problems with individual providers. OKDHS shares complaint/incident reports resulting from all sources and Provider Audit reports with the OHCA and the OHCA participates in QMS Council meetings in which complaint/incident and Provider Audit reports are reviewed and trends and/or major issues are addressed.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. Sub-assurance: Service plans address all participants’ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.
For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and Percentage of member Service Plans that address all participants’ assessed needs, including health and safety risk factors, either by the provision of waiver services or other means. Numerator: Number of members for whom all assessed needs, including health and safety risk factors, have been addressed Denominator: All members evaluated

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

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Continuous and Ongoing

Performance Measure:
Number and Percent of member Service Plans that support personal goals either by the provision of waiver services or other means. Numerator: Number of members for whom personal goals have been addressed in the service plan Denominator: All members evaluated in analysis period

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

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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.

**Performance Measure:**

Number and Percentage of member service plans received 30 days prior to the end date of the existing service plan. Numerator: Members with reassessment service plans received at least 30 days prior to end of existing service plan Denominator: Members with reassessments service plans due within the analysis period

**Data Source** (Select one):

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If ‘Other’ is selected, specify:
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Confidence Interval = 95%
Performance Measure:
Number and Percentage of Service Plans developed using standardized assessment tool consistent with State Policy. Numerator: Number of Service Plans that used standardized assessment tool Denominator: Number of Service Plans developed and authorized

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

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c. **Sub-assurance:** Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s 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 Percentage of enrolled members with a currently active service plan updated within twelve months of the previous plan. **Numerator:** Members with a currently active service plan updated within twelve months of the previous plan **Denominator:** All enrolled/active Members

**Data Source** (Select one):

- **Other**
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Performance Measure:
Number and Percentage of member service plans revised when warranted by changes in the member’s needs. Numerator: Members with service plan amendments to address all needs Denominator: Members with progress notes indicating need for new services or changes in service

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

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**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 services provided in the type, scope, amount, duration and frequency specified in the service plan. Numerator: Member service plans in which monitoring documents that services were provided in the type, scope, amount, duration and frequency specified in the service plan. Denominator: All Member Service Plans reviewed

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

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e. Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and 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 Percentage of members offered choice between waiver services and institutional care. Numerator: Number of members offered choice between waiver services and institutional care as documented by signed Freedom of Choice Form Denominator: Number of member records reviewed

**Data Source** (Select one):

- [ ] Other
  If ‘Other’ is selected, specify:

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Performance Measure:
Number and Percentage of members with appropriately completed and signed service plan indicating choice of waiver services and providers. Numerator: Number of members offered choice of services and among service providers as documented by signed Service Plan Form with Service/Provider Choice indicator Denominator: Number of member records reviewed

Data Source (Select one):
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ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

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

The OHCA Director of Waiver Administration and Development will be directly responsible for mediating any individual problems pertaining to administrative authority. The Director of Waiver Administration and Development will work with the designated OKDHS Point of Contact to resolve any problems in a timely manner. Problems requiring system change or additional staff will be addressed through the ADvantage Quality Management Strategies Council (QMSC) which may form workgroups involving appropriate personnel to resolve issues more timely and effectively or to initiate systemic changes to address re-occurring issues/performance failures. These problems and resolutions will also be reported in the LTCQIC meetings.

Individual problems may be discovered during monitoring activities by the State or by any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring are described in each performance measure of this appendix.

If as part of remediation, a corrective action plan is required, the plan will detail the steps to be taken to prevent future performance failures along with the timeframe, not to exceed 30 days, for implementation of the corrective actions. Any performance failures, or remediation corrective actions, that may result in a loss of eligibility or reduction of services for one or more individual members will be referred to the EOCC for appropriate follow-up to safeguard the health and safety of members affected.

The options for remediation of Service Plan assurances performance failures are listed below:

Remediation for Service Plan Assurances:

OKDHS Level of Care, Service Plan Authorization and Provider Audit units each play a role in monitoring that service plans are developed and authorized in accordance with waiver and Medicaid Agency policy. If any instances are found in which documentation that a member has been offered choice between waiver services and institutional care is missing, the OKDHS Nurse Programs Assistant Administrator (NPAA) contacts directly for resolution the Area Nurse responsible for the LOC evaluation within the geographic area in which the failure occurred and, if deemed necessary, the OKDHS NPAA will be required to submit, within five working days of request, a corrective action plan to the OKDHS HCBS Unit Programs Administrator. If documentation choice of HCBS/institutional care does not exist, the member is contacted and documentation of choice is obtained.

If any instances are found in which a member’s plan fails to address all the member’s assessed health and safety needs, or a member’s service plan is received less than 30 days prior to the end date of the existing plan, or the member’s plan has not been developed using the state approved assessment instrument, or a member is found not to have a currently active service plan, or a member’s plan documentation fails to confirm that the member has been informed of both choice of waiver services and choice of providers, the OKDHS ADvantage Programs Assistant Administrator for Service Plan Authorizations contacts directly for resolution the Provider and appropriate OKDHS staff and, if deemed necessary, the Programs Assistant Administrator for Service Plan Authorizations will be required to submit, within five working days of request, a corrective action plan to the Programs Administrator of the ADvantage Administration Unit. Performance failures due to provider non-compliance with requirements such as repeated failure to submit reassessment service plans timely, not addressing all assessed health and safety issues or failure to document member has been afforded choice of services and providers may result in the Case Management provider being taken off referral for a minimum of 90 days and until documentation of improved processes for meeting requirements is approved by OKDHS.

If any instances are found through provider audit in which a member’s service plan failed to address all or the member’s assessed needs or failed to support the member’s personal goals either by the provision of

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waiver services or other means, or if a member’s service plan was not revised when warranted by changes in the member’s needs, or a member’s services were not provided in the type, scope, amount, duration and frequency as specified in the plan, the OKDHS HCBS Quality Assurance Manager provides to the Provider a final audit report that includes information regarding these deficiencies that require a corrective action plan. The agency is given 30 days to submit the corrective action plan which must address all deficiencies and must include immediate resolution with time-frames for completion of correction of deficiencies for plans that are still active and for which correction is reasonably feasible. Providers operating under corrective action plans are required to submit monthly Progress Reports for 4 months to the Quality Assurance Manager. At the conclusion of a corrective action cycle, the OKDHS Provider Audit unit performs a follow up audit of the Provider.

Quarterly, OKDHS will provide reports of remediation and corrective action plans (if any) to the ADvantage QMSC and to the OHCA Director of Waiver Administration and Development.

ii. Remediation Data Aggregation

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

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iii. 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)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Consumer-Directed Personal Assistance Services and Support (CD-PASS): CD-PASS consists of Personal Services Assistance, Advanced Personal Services Assistance and Administrative Financial Management Services that enable an individual in need of assistance to reside in their home and the community of their choosing rather than in an institution and allow the individual to carry out functions of daily living, self care, and mobility.

Member as Employer

For CD-PASS, the member is the Employer of the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA). This means the member:

- Is the Common Law Employer-of-record as defined by the Internal Revenue Service (IRS);
- Recruits, hires and, as necessary, discharges the PSA/APSA;
- Provides instruction and training to the PSA/APSA on tasks to be done;
- Determines where and how the PSA/APSA works, develops the work schedule per week, defines what is to be accomplished in accordance with the service plan and, within Individual Budget Allocation limits, determines hourly wages to be paid for the work;
- Supervises employee work time and documents work time unless documented by Interactive Voice Response Authentication (IVRA) system; and,
- Provides tools and materials for work to be accomplished.

The member may designate an adult family member or friend, an individual who is not a PSA or APSA to the member, as an “authorized representative” to assist in executing these Employer functions.

With support as needed from the Administrative Financial Management Services Provider, the member is responsible for implementing the Employer functions. The member recruits and hires a PSA/APSA, negotiates an employment agreement; develops a job description and outlines employee responsibilities based upon the service plan goals; defines tasks to be performed and provides training; and determines salary within the limits of the Individualized Budget Allocation (IBA).

The member coordinates with their Consumer Directed Agent/Case Manager (CDA/CM) to finalize the service plan. The CDA/CM is responsible for submitting the CD-PASS services ADvantage Service Plan addendum to the AA for authorization and for notifying existing duplicative agency service providers of the end date for those services. The member may continue to receive some of their services from agency providers; however, the CD-PASS IBA and the PSA/APSA unit authorizations will be reduced proportional to agency service utilization.

CD-PASS members will be responsible for training their PSAs/APSAs, although, when deemed necessary, ADvantage Nursing services may be authorized to provide assistance with training. OKDHS is the IRS Fiscal Agent for the CD-PASS program and contracts through an RFP process with a fiscal subagent that will perform financial management and payroll services for members who choose the CD-PASS service option.

The Individualized Budget Allocation (IBA)

For CD-PASS services, the IBA sets the overriding cost constraint at the individual member level. The IBA is the annualized budget amount calculated to cover reimbursement for CD-PASS services of Personal Services Assistance (PSA) and/or Advanced Personal Services Assistance (APSA) and program authorized individual-directed purchases of goods and services required for delivery of PSA/APSA services.

At the time of CD-PASS service plan initial implementation (initial or annual reassessment plan), the CDA/CM assists the member with developing a service plan budget based on the amount of personal care services requested,
the pay rate for the employee and program allowable individual-directed purchases of goods and services that the
member needs to budget for the plan year. The IBA process is described in Oklahoma Administrative Code
(OAC317:30-5-764) which is maintained by the Office of Administrative Rules within the Office of Secretary of
State and posted on the Secretary of State website.

The IBA defines the level of program financial resources required to meet the member’s need for CD-PASS
services. If the member’s need for services changes due to a change in health/disability status and/or a change in
the level of support available from other sources to meet needs, the CDA/Case Manager, based upon an updated
assessment, amends the service plan to increase CD-PASS service units appropriate to meet additional member need.
The AA, upon favorable review, authorizes the amended plan and updates the member’s IBA.

Each ADvantage Service Plan with CD-PASS services will be required to have a CD-PASS emergency back-
up/emergency response capability in the event a provider of services and supports essential to the individual’s health
and welfare is not available. Any of the following may be used in planning for the backup:

• Identification of a qualified substitute provider of PSA or APSA and preparation for their quick response to provide
backup services when called upon in emergency circumstances; or,
• Identification of informal supports that will step in to provide backup services in emergency circumstances;
• Identification of a qualified substitute ADvantage agency service provider (Adult Day Care, Personal Care or
Nursing Facility Respite provider) and preparation for their quick response to provide backup services when called
upon in emergency circumstances.

In addition, the following system backups will be available to each CD-PASS member:
• Case Management providers are required to provide members with 24 hour/7 day a week, toll-free access to Case
Management resources to arrange intervention assistance in response to a health or safety emergency;
• If the member meets need criteria, a Personal Emergency Response System (PERS) may be authorized as an
additional backup alert for emergency assistance;
The AA may expeditiously authorize and facilitate access to ADvantage Adult Day Care, Nursing Facility Respite
and/or Agency Personal Care services for backup support to the member in emergency circumstances.

The CDA/CM provides information to the member about the option to terminate self-direction. If the member
terminates self-direction, the case manager will arrange for services to be provided by an ADvantage Home Care
agency of the member’s choosing.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.
Select one:

- **Participant: Employer Authority.** As specified in Appendix E-2, Item a, the participant (or the participant’s
  representative) has decision-making authority over workers who provide waiver services. The participant may
  function as the common law employer or the co-employer of workers. Supports and protections are available for
  participants who exercise this authority.

- **Participant: Budget Authority.** As specified in Appendix E-2, Item b, the participant (or the participant’s
  representative) has decision-making authority over a budget for waiver services. Supports and protections are
  available for participants who have authority over a budget.

- **Both Authorities.** The waiver provides for both participant direction opportunities as specified in Appendix E-2.
  Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. Check each that applies:

- Participant direction opportunities are available to participants who live in their own private residence or
  the home of a family member.
- Participant direction opportunities are available to individuals who reside in other living arrangements
  where services (regardless of funding source) are furnished to fewer than four persons unrelated to the
  proprietor.
- The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:
Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (select one):

- Waiver is designed to support only individuals who want to direct their services.
- The waiver is designed to afford every participant (or the participant’s representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

CD-PASS Service Eligibility and Member Choice

The CD-PASS service is an option for ADvantage members who meet the following criteria:
- Reside in the CD-PASS Geographic Target Area defined in the Waiver Request section on Page “Application: 6” of this waiver document under item “C: Statewideness”;
- Have an existing need for CD-PASS services to prevent institutionalization; and
- Assurance of member health and safety with CD-PASS services can reasonably be made based on a review of service history records.

Within CD-PASS, as contrasted with Agency provided service delivery, the member’s health and safety is more dependent upon the member’s capacity and willingness to assume an active role in: service planning, provider recruitment, training, management and supervision, CD-PASS service budgeting and fiscal management, monitoring and managing health and preparation for emergency backup. The AA reviews the UCAT and service history records to evaluate member capacity and willingness to assume responsibility. The ADvantage Program provides support to the CD-PASS participant in each area in which the review indicates member capacity to assume responsibility requires assistance. For example, an ADvantage Consumer-Directed Agent/Case Manager (CDA/CM) assists with service and emergency backup planning; an FMS assists, as needed, to prepare, equip and assist the member in their employer role to recruit, train, manage and supervise PSA and APSA providers and to assist with CD-PASS services budgeting and fiscal management; and, an ADvantage skilled nurse may, as needed, assist in training the PSA or APSA provider on tasks requiring clinical expertise and in monitoring and addressing member health conditions. However, in each area, the role of the provider is to assist, not assume the responsibility. Based upon review of service history records, any one of the following would be basis to deny a request for CD-PASS due to inability to assure member health and safety:

- The member is not willing to assume responsibility, or to enlist an “authorized representative” to assume responsibility, in one or more areas of CD-PASS such as in assuming the role of employer of the PSA or APSA provider; or,
- The member has a recent history of self-neglect or self-abuse within the past twelve months that is confirmed by Adult Protective Services and does not have an “authorized representative” with capacity to assist with CD-PASS responsibilities.
- The Member has an MSQ of 12 or more and is unable to obtain an Authorized Representative who is willing to assist with employer responsibilities.
- Based upon the Member’s UCAT and/or other assessment documentation, participation in the CD-PASS service option would jeopardize the Member’s health and/or safety as determined by clinical nurse review.

If the member decides not to direct their services or does not meet participation criteria, Agency Personal Care and/or other ADvantage services of member choice are arranged to meet the needs of the member.

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Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The AA will provide information on the CD-PASS service option to all new ADvantage members within the CD-PASS geographic target area. Whenever a new member who resides in the CD-PASS option availability area is referred to the AA for ADvantage enrollment and service plan development, the AA mails to the member’s home address a CD-PASS service option hand book.

The CD-PASS service option hand book contains basic information about the CD-PASS service option including the following:

- Description of the CD-PASS service option
- The services that may be self-directed
- A list of the responsibilities of the member choosing self-directed option
- Resources available to members who choose self-direction
- How to request the CD-PASS service option and
- A toll-free 800 number to call to obtain additional information about the CD-PASS service option.

The member may request CD-PASS services from their Case Manager or call an AA-maintained toll-free number to request CD-PASS services.

The member must make a voluntary Informed Choice to participate in CD-PASS. To support the decision-making process, the AA will provide the member, and as applicable their designated “authorized representative” or “legal representative”, a self guided orientation to CD-PASS including the member’s role as Employer and the role of each of the other participants in this unique service delivery system.

As part of the informed choice decision-making process for CD-PASS, the AA will provide consultation and assistance during enrollment into this service option. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under CD-PASS, the supports available to assist them to successfully perform Employer responsibilities and an overview of the potential risks involved.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State’s policy concerning the direction of waiver services by a representative (select one):

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (check each that applies):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The member may designate an “authorized representative” to assist them with their employer responsibilities. The designated “authorized representative” may counsel and advise the member regarding any and all CD-PASS activities and decisions for which the member is responsible and take actions on behalf of the member when directed by the member. If the member chooses to designate an “authorized
representative”, the designation identifying the “willing adult” to assume this role and responsibility is documented with dated signatures of the member, the designee and the member’s Case Manager or the AA staff.

A person may not make decisions for or on behalf of the member or sign for the member unless the person has legal standing as to make decisions on behalf of the member. To be the member’s “legal representative”, the person must have legal standing to make decisions on behalf of the member such as having guardianship or power of attorney for the member. An individual hired to provide Personal Services Assistance or Advanced Personal Services Assistance to a member may not be an “authorized representative” or a “legal representative” of the member.

The CDA/CM monitors service delivery and the performance of the member’s designated “authorized representative” or “legal representative” to function in the best interest of the member. The designation of an Authorized Representative and the legal status of the member is reviewed annually by the Case Manager and submitted to the AA at the annual service plan reassessment.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Employer Authority</th>
<th>Budget Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer-Directed Personal Assistance Supports and Services</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. Select one:

- Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).
  Specify whether governmental and/or private entities furnish these services. Check each that applies:
  - ✔ Governmental entities
  - ✔ Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. Select one:

- ✔ FMS are covered as the waiver service specified in Appendix C-1/C-3
  The waiver service entitled:

- ✔ FMS are provided as an administrative activity.

Provide the following information

- ✔ Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:
OKDHS ADvantage Administration in coordination with a contracted private entity provides Administrative Financial Management Services for members who choose to self-direct their services through ADvantage CD-PASS. The private entity that serves as the IRS Fiscal Sub-agent to assist OKDHS in providing ADvantage FMS is selected as a result of a competitive bid following procedures outlined in the Oklahoma Central Purchasing Act.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

OKDHS FMS administrative services are compensated as part of bundled administrative funds for waiver administrative responsibilities. The private entity that serves as the IRS Fiscal Sub-agent is paid a flat monthly rate for each member per competitive contract bid award.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (check each that applies):

Supports furnished when the participant is the employer of direct support workers:

- Assist participant in verifying support worker citizenship status
- Collect and process timesheets of support workers
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- Other

Specify:

Administrative Financial Management Services may include assistance with employer responsibilities. In addition, FMS provides to the member, to the extent needed and desired by the member, orientation and instruction regarding employer responsibilities as well as employer information and management guidelines, material, tools and staff consultant expertise to support and assist the member to successfully perform Employer-related functions.

In addition, Administrative Financial Management Services includes responsibility for assisting the member in obtaining criminal and abuse registry background checks, on behalf of the member, for prospective hires for PSAs or APSAs and for performing Internal Revenue Services (IRS) fiscal reporting agent and other financial management tasks and functions including employer payroll and associated mandatory withholding for taxes performed on behalf of the member as employer of the PSA or APSA.

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant’s participant-directed budget
- Track and report participant funds, disbursements and the balance of participant funds
- Process and pay invoices for goods and services approved in the service plan
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget
- Other services and supports

Specify:

The FMS provider supports waiver Members in establishing and tracking the member’s Individual Budget Allocation. FMS verifies that all PSA and/or APSA employees hired by a member meet Service Provider qualifications for ADvantage Provider certification and facilitates processing of a Medicaid contract for each PSA and APSA prior to hire.

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
✓ Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

OKDHS reviews monthly reports that track and summarize the performance of FMS contracted entity in meeting contract performance standards for CD-PASS member customer support. In addition, OKDHS and OHCA staffs participate in monthly teleconference calls with FMS contracted entity to review management reports and review issues related to contracted responsibilities. OKDHS AA staff review on an ongoing basis individual and aggregated reports that track CD-PASS member budget disbursements and meet as needed with the FMS contracted entity to address specific issues with Members or program operation. OKDHS and OHCA regularly review FMS contracted entity performance of contracted responsibilities during quarterly Quality Strategy Council or during LTSS Council meetings. Annually the OKDHS Contract Manager submits a summary Professional Services Evaluation report on PPL performance to the OKDHS Contracts & Purchasing Unit.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (check each that applies):

✓ Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

CD-PASS Planning and Supports Coordination

The member freely chooses an ADvantage Case Management provider. The ADvantage Case Management provider assigns to the CD-PASS member a Case Manager that has successfully completed training on CD-PASS including training on Independent Living Philosophy, the individual budgeting process and process guidelines, and Person-centered planning. Case Managers that have completed this specialized CD-PASS training are referred to as Consumer-Directed Agent/Case Managers (CDA/CM) with respect to their CD-PASS service planning and support role in working with CD-PASS members.

The role of the CM/Consumer Directed Agent is to facilitate the interdisciplinary team process by supporting the key principles of person-centered planning.

Principles of Person-Centered Planning are as follows:

• The person is the center of all planning activities.
• The member and their representative, or support team, are given the requisite information to assume a controlling role in the development, implementation and management of the member’s services.
• The individual and those who know and care about him or her are the fundamental sources of information and decision-making.
• The individual directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals and support needs.
• Person-centered planning results in personally-defined outcomes.
The CDA/CM will provide support to the member in this person-centered planning process, including providing information about qualified providers of ADvantage services and information on community resources for informal and non-ADvantage formal services of interest to the member. The CDA/CM is responsible for submitting the developed plan to the AA for approval. ADvantage requirements for Service plan monitoring and review for CD-PASS member plans are the same as for other ADvantage service plans.

In the planning process, CDA/CM helps the member define support needs, service goals and service preferences including access to and use of generic community resources. Consistent with member-direction and preferences, the CDA/CM provides information and helps the member locate and access community resources. Operating within the constraints of the Individual Budget Allocation and using the person-centered planning approach, the CDA/CM assists the member in translating the assessment of member needs and preferences into an individually tailored, personalized service plan that includes a plan for back-up assistance. The CDA/CM prepares an ADvantage Service plan or plan amendment to authorize CD-PASS Personal Service Assistance units consistent with this individual plan. The CDA/CM monitors the member’s well being and the quality of CD-PASS supports and services and assists the member in revising the CD-PASS service units authorization as needed.

If the plan requires Advanced Personal Services Assistance (APSA), the CDA/CM works with the member and, as appropriate, arranges for skilled nurse training for the member or member’s family and the APSA to ensure that the APSA performs the specific Health Maintenance tasks safely and competently.

Whenever a member and a Provider of ADvantage services cannot agree about a service, or about the appropriate frequency, duration or other aspect of the service, or disagree about a behavior/action of the member, or of the provider, and either the CDA/CM, the provider or the member, or the member’s family or authorized representative, believe that the disagreement poses a significant risk to member health or safety, the CDA/CM uses the ADvantage Risk Management process to resolve the disagreement. If the behavior/action of the CDA/CM is in dispute, the AA uses the ADvantage Risk Management process to resolve the disagreement. A description of the ADvantage Risk Management process is on file with the State Medicaid Agency. The description of the ADvantage Risk Management process includes guidelines and criteria for: determining circumstances under which to invoke the process, parties to include in the process, timeline for process resolution, an evidence-based evaluation process to determine risk to member health and safety, requirements for a consensus agreement on “reasonable acceptable risk”, and process documentation forms including requirement for a summary statement of resolution agreement and actions to be taken.

**Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

<table>
<thead>
<tr>
<th>Participant-Directed Waiver Service</th>
<th>Information and Assistance Provided through this Waiver Service Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td></td>
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<tr>
<td>Respite</td>
<td></td>
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<tr>
<td>Adult Day Health</td>
<td></td>
</tr>
<tr>
<td>Advanced Supportive/Restorative Assistance</td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
</tr>
<tr>
<td>Environmental Accessibility Modifications</td>
<td></td>
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<tr>
<td>Personal Care</td>
<td></td>
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<tr>
<td>Therapy Services</td>
<td></td>
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<tr>
<td>Home-Delivered Meals</td>
<td></td>
</tr>
<tr>
<td>Specialized Medical Equipment and Supplies</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td></td>
</tr>
<tr>
<td>Personal Emergency Response Systems</td>
<td></td>
</tr>
<tr>
<td>Institution Transition Services</td>
<td></td>
</tr>
<tr>
<td>Consumer-Directed Personal Assistance Supports and Services</td>
<td></td>
</tr>
</tbody>
</table>

https://wms-mmdl.cdsvdc.com/WMS/faces/protected/35/print/PrintSelector.jsp
**Participant-Directed Waiver Service Information and Assistance Provided through this Waiver Service Coverage**

<table>
<thead>
<tr>
<th>Assisted Living Services</th>
<th>Prescribed Drugs</th>
</tr>
</thead>
</table>

✓ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Administrative Financial Management Services may include providing information and assistance with employer responsibilities. This information and assistance may be provided by OKDHS or by the contracted fiscal sub-agent. The FMS provides to the member, to the extent needed and desired by the member, orientation and instruction regarding employer responsibilities as well as employer information and management guidelines, material, tools and staff consultant expertise to support and assist the member to successfully perform Employer-related functions. An Employer orientation packet is provided to each CD-PASS participant upon enrollment.

OKDHS FMS administrative services are compensated as part of bundled administrative funds for waiver administrative responsibilities. The private entity that serves as the IRS Fiscal Sub-agent is paid a flat monthly rate for each member per competitive contract bid award.

OKDHS reviews monthly reports that track and summarize the performance of FMS contracted entity in meeting contract performance standards for CD-PASS member customer support. In addition, OKDHS and OHCA staffs participate in monthly teleconference calls with FMS contracted entity to review management reports and review issues related to contracted responsibilities. OKDHS AA staff review on an ongoing basis individual and aggregated reports that track CD-PASS member budget disbursements and meet as needed with the FMS contracted entity to address specific issues with Members or program operation. OKDHS and OHCA regularly review FMS contracted entity performance of contracted responsibilities during quarterly Quality Strategy Council or during LTSS Council meetings. Annually the OKDHS Contract Manager submits a summary Professional Services Evaluation report on PPL performance to the OKDHS Contracts & Purchasing Unit.

**Appendix E: Participant Direction of Services**

**E-1: Overview (10 of 13)**

**k. Independent Advocacy (select one).**

- ☐ No. Arrangements have not been made for independent advocacy.
- ☐ Yes. Independent advocacy is available to participants who direct their services.

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

**Appendix E: Participant Direction of Services**

**E-1: Overview (11 of 13)**

**l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:
ADvantage members may voluntarily terminate any services at any time including CD-PASS services. If a member voluntarily request termination of participation in CD-PASS, the CDA/CM works with the member to develop agency services of the member’s choice to replace CD-PASS services to meet member needs. Existing PSA and/or ASPA services continue as authorized, or the member’s backup plan of choice is implemented, until agency replacement services start.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

**m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination of member directed services may occur if it is determined through documentation that the individual can no longer effectively self-direct their services due to:

- Participant abuse or exploitation of their employee;
- Participant falsification of a time-sheet or other work record;
- Participant, even with FMS assistance, is unable to operate within their IBA;
- Participant is unable to follow the employer guidelines and/or processes established by OKDHS; or,
- Participant UCAT documents that the member is “high risk” and would need assistance in performing employer responsibilities and the member is unable or unwilling to obtain an Authorized Representative to assist.

If termination of member self-direction occurs, the CDA/CM works to ensure continuity of service and member health and welfare during the transition period. The CDA/CM assists the individual replace CD-PASS services with comparable services from one or more qualified provider agencies selected by the member.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

**n. Goals for Participant Direction.** In the following table, provide the State’s goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

> Table E-1-n

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Employer Authority Only</th>
<th>Budget Authority Only or Budget Authority in Combination with Employer Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Participants</td>
<td>Number of Participants</td>
</tr>
<tr>
<td>Year 1</td>
<td></td>
<td>650</td>
</tr>
<tr>
<td>Year 2</td>
<td></td>
<td>750</td>
</tr>
<tr>
<td>Year 3</td>
<td></td>
<td>900</td>
</tr>
<tr>
<td>Year 4</td>
<td></td>
<td>1300</td>
</tr>
<tr>
<td>Year 5</td>
<td></td>
<td>1800</td>
</tr>
</tbody>
</table>

Appendix E: Participant Direction of Services

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

**a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

**i. Participant Employer Status.** Specify the participant’s employer status under the waiver. Select one or both:
Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- [x] Recruit staff
- [ ] Refer staff to agency for hiring (co-employer)
- [ ] Select staff from worker registry
- [x] Hire staff common law employer
- [x] Verify staff qualifications
- [x] Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

Cost of criminal background investigations are incorporated in the Member/Employer’s budget as an allowable expenditure for necessary goods or services.

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

- [x] Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
- [x] Determine staff wages and benefits subject to State limits
- [ ] Schedule staff
- [ ] Orient and instruct staff in duties
- [ ] Supervise staff
- [ ] Evaluate staff performance
- [x] Verify time worked by staff and approve time sheets
- [x] Discharge staff (common law employer)
- [ ] Discharge staff from providing services (co-employer)
- [ ] Other

Specify:

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**Appendix E: Participant Direction of Services**

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*
i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- [ ] Reallocate funds among services included in the budget
- [x] Determine the amount paid for services within the State's established limits
- [ ] Substitute service providers
- [x] Schedule the provision of services
- [x] Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- [x] Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- [x] Identify service providers and refer for provider enrollment
- [ ] Authorize payment for waiver goods and services
- [x] Review and approve provider invoices for services rendered
- [ ] Other

Specify:

Appendix E: Participant Direction of Services

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

b. **Participant - Budget Authority**

ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The Individualized Budget Allocation (IBA)

The member and authorized representative (if any), along with his or her CDA/CM develops the service plan that includes a budget for the services that are self-directed. The member’s assessed needs determine the intensity, frequency and duration of services developed within the service plan.

For CD-PASS services, the IBA sets the overriding cost constraint at the individual member level. The IBA is the annualized budget amount calculated to cover reimbursement for CD-PASS services of Personal Services Assistance, Advanced Personal Services Assistance and incidental goods or services necessary to support Member/Employer in carrying out Employer responsibilities or for delivery of authorized CD-PASS services.

The CDA/CM completes the service plan and the budget. The AA reviews the budget and service plan to assure compliance with cost methodology within the waiver program. When the service plan is approved, the information is transmitted to the fiscal subagent to establish a budget account for each self-directed member and their services.

The calculation tool and description of the Individualized Budget Allocation (IBA) Expenditures Accounts Determination process are on file with OHCA. In addition, the description of the IBA Expenditure Accounts Determination process is described in Oklahoma Administrative Code (OAC317:30-5-764) which is maintained by the Office of Administrative Rules within the Office of Secretary of State and posted on the Secretary of State website.
Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The CDA/CM works with the member to determine the CD-PASS individual services needed, the budgeted amounts for each service and the total CD-PASS IBA. The CDA/CM confirms that the member understands the established CD-PASS budget amounts included in the service plan and obtains the member's signature on the service plan. The member may request an adjustment in the services and budget amount at any time through the CDA/CM.

The following is the notice of right to request a fair hearing that is provided above the member signature line on each service plan:

“I have been informed of my right to request a fair hearing if I disagree with any action taken regarding my Medicaid services. A fair hearing is intended to safeguard my rights and interests by affording me due process. I understand I have the right to appeal any action of the Oklahoma Department of Human Services which I consider improper by reporting my complaint verbally or in writing to a local county office.”

In addition, at any time a negative action occurs or a member perceived negative action occurs, the CM informs the member of their right to a fair hearing and may assist the member to obtain the appropriate forms, phone contacts etc to make the request.

For a participant’s CD-PASS budget amount to be reduced, the CDA/CM would amend the service plan line to reflect the reduction. The member would be afforded the opportunity to review and sign the amended service plan and indicate whether they agreed with the change or not. The notice of Right to Fair Hearing appears just above the signature line. In addition, the CM informs the member of their right to a fair hearing if the member disagrees with the change.

The CDA/CM submits the CD-PASS budget with the service plan to the AA for approval. The fiscal agent (FMS provider) communicates the confirmed budget allocation after the service plan has been approved. The fiscal agent provides a copy of the approved budget to the member. Each month the fiscal agent provides the member detailed information of expenditures for the previous month and overall budget status.

The IBA calculation and total is reviewed by the AA during the CD-PASS service eligibility determination process and service plan authorization process. In addition, based upon the member record, UCAT review and other available information, the AA provides FMS support to cover the CD-PASS member’s Employer Support needs.

The IBA defines the resources required to meet the member’s need for CD-PASS services. If the member’s need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the Case Manager, based upon an updated assessment, amends the service plan to increase CD-PASS service units appropriate to meet additional member need. The AA, upon favorable review, authorizes the amended plan. The member, with assistance from the fiscal agent, reviews and revises the IBA Expenditure Accounts calculation annually or more often if necessary.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. Select one:

- Modifications to the participant directed budget must be preceded by a change in the service plan.
The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Monthly, the FMS contractor produces an individualized IBA status report for each CD-PASS participant which is mailed to the participant. The monthly status report includes the expected expenditures and the actual expenditures and monthly balance for each service.

Independently, the CDA/CM monitors the CD-PASS participant monthly regarding adequacy of service delivery and satisfaction with services. The CDA/CM monitoring includes review with the member of status report expenditure variance and assistance to the member in making any needed adjustments to stay within the budget allocation.

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.

Fair Hearings regarding eligibility are heard by OHCA. Applicants for the waiver are informed of this opportunity in written information presented in the first meetings with the member about the ADvantage waiver.

Service appeals are heard by OHCA. If a participant or applicant believes he or she was not given a choice of home and community-based services as an alternative to institutional care, denied the services of their choice or the provider of their choice, or whose services are denied, suspended, reduced or terminated, the individual may request a hearing through the OHCA Legal Division. At the hearing, the individual will have the opportunity to express his or her concerns to the hearing officer. The individual may be represented by counsel if they desire. This is described in OAC 317:2-1-2.

During the assessment visit to establish medical eligibility, the OKDHS nurse explains to the member (and/or his/her legal representative) his/her rights to a Fair Hearing (Part D of the Member Consents and Rights form) as well as how the member may request a Fair Hearing.

In addition, as part of the application process, the applicant is notified by the OKDHS worker of his/her rights and responsibilities including the right to a fair hearing. These are listed on the Comprehensive Application and Review Form FSS-1. The applicant has the right to:
• be treated equally regardless of race, color, age, sex, handicap, religion, political belief, or national origin
• have information kept confidential, unless directly related to the administration of OKDHS programs
• request a fair hearing, either orally or in writing if the applicant disagrees with any action taken
• be represented at the hearing by a designee
• have the application processed promptly
• obtain assistance from OKDHS in completing this application or in obtaining required verification
• reapply at any time benefits stop
• receive information about programs administered by OKDHS.

The member is informed by the OKDHS staff and by the Case Manager of the member’s right to receive a fair hearing regarding any decision with potentially adverse impact on the member including choice of service setting (institution or waiver services), choice of provider or of service, or denial, reduction, suspension or termination of services. Appeals regarding services are directed to the OHCA.

When action is taken on a member’s case, the member is advised in writing by a computer-generated notice of the action, the reason for the action, and rights to appeal. Copies of the notices are kept in the CMS-certified MMIS. The member is informed that a request for a fair hearing regarding eligibility must be submitted in writing to the Legal Division of OHCA, P.O. Drawer 18497, Oklahoma City, OK 73154-0497. The applicant is also advised of the right to legal counsel at the hearing by either a private attorney or free legal help. The written notice includes information about how to access free legal help, where and how to file an appeal, and the time frame in which an appeal must be filed. The Request for a Fair Hearing explains that the member will continue to receive services if a hearing is requested until after a decision is made.

The member also receives written information about the right to request a Fair Hearing and the steps in the process regarding appeals with respect to services. The member is to use the LD-1 form to file a request. The LD-1 form is to be mailed to:
Oklahoma Health Care Authority
Grievance Docket Clerk
Legal Division
P.O. Drawer 18497
Oklahoma City, Oklahoma 73154-0497

OHCA Fax Number is (405) 530-3455
OHCA Docket Clerk Telephone Number is (405) 522-7217

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.

OHCA understands that the members eligible for the ADvantage waiver have many needs that affect their medical services while being served in the community. Moreover, the agency recognizes that an additional dispute resolution process would be helpful for persons who desire additional medical service beyond those authorized by the agency.

Therefore, the agency will offer dispute resolution in addition to the fair hearing process; however, the member is informed that making use of the dispute resolution process is not a pre-requisite or substitute for the fair hearing process. Additional dispute resolution is available for both eligibility and medical services dispute issues. Dispute resolution must be concluded within 45 days of the request by the member. The process begins with an application for additional dispute resolution. Additional dispute resolution will be conducted between the member, legal services
and OHCA care management unit. It may involve a meeting with the member in their home. No admission against interest made in the additional dispute resolution process may be utilized as evidence by parties at the fair hearing.

The additional dispute resolution process will attempt to include other state agencies as well as other social services to the extent they can help the member with their medical needs. Additionally, the additional dispute resolution process will be used to resolve disputes regarding medical care.

If dispute resolution does not resolve the member’s dispute, the fair hearing process will continue.

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:

Oklahoma Department of Human Services (OKDHS)

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).

OKDHS manages a statewide complaint/concern discovery and remediation system for the ADvantage Program that offers timely response to grievances/complaints. Through a toll-free 1-800 telephone number, the Resource Center/Escalated Issues unit provides a centralized avenue for complaints, inquiries, or health and safety issues from members, friends, family, state agencies, providers and the community at large. The Resource Center/Escalated Issues unit is designed to help safeguard the health and safety of members served through the ADvantage Program. As part of their orientation to the ADvantage Program, members are instructed to call the 1-800 number with complaints, concerns or requests for information. The member is informed that filing a grievance or making a complaint through the Resource Center/Escalated Issues unit is not a pre-requisite or substitute for a Fair Hearing – that the member retains, at all times, the right to request a fair hearing. However, by utilizing an 800 telephone number, calls are taken, information recorded, and a process begun than involves the appropriate individuals or agencies to achieve resolution. Each complaint call is assigned to OKDHS staff to research the issue and to work collaboratively with all parties as needed to facilitate resolution of the issue. The Resource Center/Escalated Issues unit system tracks the status and categories/subcategories of complaints and identifies areas in the system for potential quality activities. Timelines for prompt resolution have been established depending on the category/subcategory of issue. OKDHS staff follows up on all issues until resolution is achieved. The major types of grievances/complaints that participants register may be categorized as follows:

Category - Health and Safety
Subcategory - Abuse, Neglect or Exploitation

Description/Response Timeline - Allegation of a possible abuse, neglect or exploitation issue – Same Day Response.
Mechanisms used to resolve inquiry/complaint: Allegation reported to Adult Protective Services and to Provider Agency. If Health or Safety a factor, issue escalated to Clinical Supervisor for action/resolution.

Category - Health and Safety
Subcategory - Escalated Service Delivery Issues

Description/Response Timeline - When any issue appears to have immediate impact upon the health or safety of the Member and requires an immediate response – Same Day Response.
Mechanisms used to resolve inquiry/complaint: Issue escalated to Clinical Supervisor for action/resolution. As back-up, issue escalated to Director of Programs if Clinical Supervisor unable to achieve same-day response.
Category - Service Delivery
Subcategory - Not Receiving Services
[Note: Any service delivery issue that appears to have impact on Member’s Health or Safety will also follow the escalated service delivery process.]

Description/Response Timeline - Current, existing Member not receiving ADvantage services listed on the service plan – One business day response.
Mechanisms used to resolve inquiry/complaint: Staff coordinates with responsible provider agency for resolution.

Category - Service Delivery
Subcategory - Environmental Modifications

Description/Response Timeline - Provider / Member is requesting changes or addressing issues that require modifications to the Member's living environment plan – One business day response.
Mechanisms used to resolve inquiry/complaint: Environmental Modification staff follow-up to assist Member and/or Provider.

Category - Service Delivery
Subcategory - Medication Delivery

Description/Response Timeline - Member is not receiving some or all of the authorized medications available on the ADvantage program plan – One business day response.
Mechanisms used to resolve inquiry/complaint: Staff coordinates with responsible provider agency to work with pharmacy or RX help line.

Category - Service Delivery
Subcategory - Request for Additional Services

Description/Response Timeline - Member is requesting services that are not on current authorized service plan plan – One business day response.
Mechanisms used to resolve inquiry/complaint: Staff coordinates with responsible provider agency for resolution.

Category - Service Delivery
Subcategory - New Member Without Initial Service Plan

Description/Response Timeline - The Member has been approved for ADvantage services but service plan has not been implemented – One business day response.
Mechanisms used to resolve inquiry/complaint: Staff validates that member is eligible and works with provider to achieve timely implementation of service plan.

Category - Service Delivery
Subcategory - Dissatisfaction with Services

Description/Response Timeline - The Member is dissatisfied with the delivery of services authorized on their ADvantage service plan plan – One business day response.
Mechanisms used to resolve inquiry/complaint: Staff validates that service is an ADvantage authorized service and coordinates with provider agency for resolution.

Category - Service Delivery
Subcategory - Move

Description/Response Timeline - Member has moved and needs services at new residence plan – One business day response.
Mechanisms used to resolve inquiry/complaint: Staff validates that member’s pre-move provider agency remains on referral for new address and coordinates with current or new provider for start of services at new address.

Category - Service Delivery
Subcategory - Transfer Request

Description/Response Timeline - Request for a transfer to another provider agency and does not want to contact the
agency plan – One business day response.
Mechanisms used to resolve inquiry/complaint: Staff coordinates with provider agency to facilitate transfer to Member’s new choice.

Category - Service Delivery
Subcategory - Change of Agencies Prior to Service Delivery

Description/ Response Timeline - Member calls and requests an agency change after approval for ADvantage services but before any services are delivered plan – One business day response.
Mechanisms used to resolve inquiry/complaint: Staff contacts provider to facilitate transfer to Member’s new choice.

The Resource Center/Escalated Issues unit database provides information on member health and welfare issues and possible service delivery system gaps or inadequacies. If data identifies trends or a network provider specific issue, a morbidity and mortality review and root cause analysis may be conducted. If system issues are identified, corrective action is initiated immediately. The Resource Center/Escalated Issues unit system tracks the status and categories/subcategories of complaints and identifies areas in the system for potential quality improvement activities.

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).

The ADvantage Program requires any serious incident that harms or potentially harms a member's health, safety or well being to be immediately identified, reported, reviewed, investigated and appropriately addressed. This policy will not supersede any federal, state or regulatory body statutes, laws or regulations. The Critical Incident Reporting and Tracking System addresses all member incidents listed and defined by the policy. As required by state law, responsible parties must report abuse, neglect and/or exploitation. Adult Protective Services (APS) is the designated State Agency lead with investigative authority in the event of critical incidents involving abuse, neglect or exploitation. Discovery of member abuse, neglect and/or exploitation are to be reported immediately to APS. In addition, the provider that first identifies a critical incident is required to report the incident to the AAU on the appropriate form within one business day. The following critical incidents must be reported to the AAU: sexual abuse, physical abuse, neglect, exploitation, (any of these four must be reported to APS which is the lead investigative authority for these incidents), medication error requiring medical attention, fall or injuries requiring medical attention, loss of residence due to disaster, suicide attempt, questionable (unexpected) death, interruption of critical medical equipment supports, member lost or missing, and/or use of restraints. The member’s case manager, with the support of the AA Escalated Issues Unit, facilitates the evaluation and/or investigation process of the critical incident.

Adult Protective Services (APS) is a program within the Oklahoma Department of Human Services (OKDHS) authorized in Title 43A of the State of Oklahoma statutes, sections 10-101 through 10-111. The state has adopted the definitions of abuse, neglect and exploitation outlined in the State of Oklahoma statute (O.S. 43A § 10-103. Definitions):
Abuse: Intentional infliction of physical pain, injury, sexual abuse or mental anguish or the deprivation of food, clothing, shelter, or medical care to a vulnerable adult by a caretaker or other person responsible for providing these services” (O.S. 43A § 10-103. A.8).

Neglect: Failure to provide protection to a vulnerable adult who is unable to protect the person's own interest; or the failure to provide adequate shelter or clothing; or the harming or threatening with harm through action or inaction by either another individual or through the person’s own action or inaction because of a lack of awareness, incompetence, or incapacity, which has resulted or may result in physical or mental injury” (O.S. 43A § 10-103. A.10).

Exploitation: An unjust or improper use of the resources of a vulnerable adult for the profit or advantage, pecuniary or otherwise, of a person other than the vulnerable adult through the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense” (O.S. 43A § 10-103. A.9).

Other definitions listed in the statutes include: self-neglect, verbal abuse, sexual exploitation.

In accordance with the State of Oklahoma statute (O.S. 43A, § 10-104.A), “any person who has reasonable cause to believe a vulnerable adult is suffering from Abuse, neglect or exploitation shall report the situation to authorities as soon as the person is aware of the situation. Reports can be made to the Department of Human Services APS program, the local district attorney's office, or the local police of sheriff's department. Reporting is the individual responsibility of the person who believes the situation to be one which should be reported.

In addition, the State of Oklahoma statute (O.S. 43A § 10-104.B) states that “although the reporting requirement applies to everyone, certain professionals are specifically required by law to report situations. These include, but are not limited to, social workers, mental health professionals, and other medical professionals.

The Provider is responsible for completing their own internal investigation of all critical incidents, unless they have been directed not to do so from an authorized government entity. All investigative reports are submitted to the AA within 10 working days after the initial Critical Incident Report is completed. When a provider becomes aware of a critical incident, the provider must inform the AA Escalated Issues Unit within one working day.

The Provider coordinates their critical incident investigation and response efforts with governmental investigative authorities as required by State or Federal law. The Provider uses the following criteria in determining whether a response is adequate for resolution of the critical incident:
• An adequate description of the incident has been obtained
• Documentation reflects the assessment of the illness or injury and its impact to the Participant's health and welfare
• Documentation reflects that appropriate action has been taken to assure the member's continued health and welfare

Documented history of similar events for previous incidents in the past six months (unless there is a documented plan indicating an agreed upon procedure that has been followed, i.e. a member has a seizure disorder and a plan has already been developed of how to manage a resultant fall).

The AA Escalated Issues Unit reviews all critical incident reports and determines whether the appropriate response to each incidence occurred. The AA coordinates their investigation and response efforts with governmental investigative authorities as required by State or Federal law. The AA uses the following criteria in determining whether a response is adequate for resolution of the critical incident:
• An adequate description of the incident has been obtained
• Documentation reflects the assessment of the illness or injury and its impact to the Participant's health and welfare
• Documentation reflects that appropriate action has been taken to assure the member's continued health and welfare
• Documented history of similar events for previous incidents in the past six months (unless there is a documented plan indicating an agreed upon procedure that has been followed, i.e. a members has a seizure disorder and a plan has already been developed of how to manage a resultant fall).

In the ADvantage Program Conditions of Provider Participation (CoPP), Case Management, Home Care, Assisted Living, Hospice and Adult Day Health providers are required, as part of their Medicaid contract, to ensure that necessary safeguards have been taken to assure the health and safety of the member. Requirements specify that the provider will follow APS process for reporting potential instances of suspected abuse, neglect and exploitation.

Furthermore, the OKDHS ADvantage Administration (AA) for ADvantage Program operates a toll free telephone number (1-800-435-4711) for inquiries or complaints from members, providers, or others. staff report any
suspected incidence of abuse, neglect or exploitation to APS.

The Oklahoma Department of Human Services website for Adult Protective Services (http://www.okdhs.org/APS/printer.html§5.C) offers the following guidance on reporting potential abuse, neglect and exploitation. “The best way to make a report to the Department of Human Services is to contact the APS supervisor who has responsibility for the county where the vulnerable adult lives.” Supervisor contact information (name, address, phone number, county) is listed.

The website provides a mailing address, phone number and e-mail address for reporting potential abuse, neglect and/or exploitation.

According to State of Oklahoma statute (O.S. 43A § 10-104 C.1.), “if the report is not made in writing in the first instance, as soon as possible after it is initially made by telephone or otherwise, the report shall be reduce to writing by the Department of Human Services, in accordance with rules promulgated by the Commission for Human Services, or the local municipal police, or sheriff’s department whichever entity received the initial report.

According to State of Oklahoma statute (O.S. 43A § 10-104 A.2.a.), the person suspecting potential abuse, neglect or exploitation must make the report to the appropriate authorities as soon as the person is aware of the situation.

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.

As part of the ADvantage Program Conditions of Provider Participation, each Case Management, Home Care, Assisted Living, Hospice and Adult Day Health provider must comply with member Assurances in the delivery of services. At each new member’s orientation to the ADvantage Program, the member’s chosen case manager provides in-home orientation and education along with written materials to the member and his/her selected support systems regarding member rights and responsibilities, the grievance process and procedures, the case management’s emergency phone numbers, the ADvantage Program Consumer Inquiry Services 1-800 telephone number, health and safety procedures, and recognizing abuse, neglect and exploitation and the process for reporting any incidents of such. ADvantage Program case managers are responsible for ongoing monitoring the health and welfare of members and providing the necessary education and intervention related to abuse, neglect and exploitation of members.

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.

The AA Escalated Issues Unit reviews reports of critical events or incidents including suspected abuse, neglect or exploitation. When the AA identifies instances of potential abuse, neglect and exploitation, these instances are immediately reported to Adult Protective Services.

Adult Protective Services (APS) is a program within the Oklahoma Department of Human Services (OKDHS) authorized in Title 43A of the State of Oklahoma statutes, sections 10-101 through 10-111.

In accordance with the State of Oklahoma statute (O.S. 43A § 10-104.A), “any person who has reasonable cause to believe a vulnerable adult is suffering from Abuse, neglect or exploitation shall report the situation to authorities as soon as the person is aware of the situation. Reports can be made to the Department of Human Services APS program, the local district attorney’s office, or the local police of sheriff’s department. Reporting is the individual responsibility of the person who believes the situation to be one which should be reported.”

In addition, the State of Oklahoma statute (O.S. 43A § 10-104.B) states that, although the reporting requirement applies to everyone, certain professionals are specifically required by law to report situations. These include, but are not limited to, social workers, mental health professionals, and other medical professionals.

The Oklahoma Department of Human Services website for Adult Protective Services (http://www.okdhs.org/APS/printer.html§5.C) offers the following guidance on reporting potential abuse, neglect and exploitation. “The best way to make a report to the Department of Human Services is to contact the APS supervisor who has responsibility for the county where the vulnerable adult lives.” Supervisor contact information (name, address, phone number, county) is listed.
The website provides a mailing address, phone number and e-mail address for reporting potential abuse, neglect and/or exploitation. According to State of Oklahoma statute (O.S. 43A § 10-104 A.2.a.), the person suspecting potential abuse, neglect or exploitation must make the report to the appropriate authorities as soon as the person is aware of the situation.

In accordance with State of Oklahoma statute (O.S. 43A § 10-104 C.1.), "if the report is not made in writing in the first instance, as soon as possible after it is initially made by telephone or otherwise, the report shall be reduced to writing by the Department of Human Services, in accordance with rules promulgated by the Commission for Human Services, or the local municipal police, or sheriff's department whichever entity received the initial report. O.S. 43A Section 10-105 C.5.1., states "As soon as possible after initiating an investigation of a referral regarding a vulnerable adult, the Department shall provide to the caretaker of the alleged victim, the legal guardian and the next of kin of the vulnerable adult notification including a brief oral summary and easily understood written description of the investigation process, whether or not the caretaker, guardian or next of kin is alleged to be the perpetrator of the abuse, neglect or exploitation of the vulnerable adult."

APS investigations must be initiated with a visit to the alleged victim within 3 working days of receipt of the referral, or, in case of emergency situations, within 4 hours of receipt. According to O.S. 43A § 10-105 C.5.1., "as soon as possible after initiating an investigation of a referral regarding a vulnerable adult, the Department shall provide to the caretaker of the alleged victim, the legal guardian, and next of kin of the vulnerable adult notification including a brief oral summary and easily understood written description of the investigation process, whether or not the caretaker, guardian or next of kin is alleged to be the perpetrator of the abuse, neglect or exploitation of the vulnerable adult." Investigations are to be completed, including all documentation with a report of findings within 30 days to the District Attorney. In addition a copy of the APS report is sent, as appropriate, to the Oklahoma Department of Health, to the regulatory or licensing board, to the OKDHS Office of Consumer Advocacy and/or to the court of guardianship, if alleged victim has a legal guardian. Notification of investigative findings is reported at the same time to the alleged victim, next of kin, caretaker and guardian.

For reported critical incidents other than abuse neglect or exploitation, the AA Escalated Issues Unit evaluates reports and results of investigations which are communicated to the member and legal guardian, or next of kin, in no more than five working days. The AA Escalated Issues Unit works with the member, member's family, provider and/or others to verify that appropriate actions are taken to prevent future incidents and assure the Participant's continued health and welfare.

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 Adult Protective Services is the designated agency for overseeing instances of potential abuse, neglect and exploitation. In accordance with Title 43a Section 10-104, if staff of the Oklahoma Department of Human Services Aging services division, and other OKDHS staff that work with ADvantage members, have reasonable cause to believe that a vulnerable adult is a victim of abuse (including verbal abuse), neglect (including self neglect and financial neglect), or exploitation, a report is made to the Department's Adult Protective Services (APS). This is done through the statewide abuse hotline (1-800-522-3511), through the OKDHS web link of http://apps6/aps, and through contact with APS staff in the local offices.

In instances of substantiated abuse, neglect, or exploitation (a/n/e) by paid caregivers, a referral is sent to the OKDHS Office of Consumer Advocacy (OCA) for further investigation. Results, including progression to the caregiver being placed on the Department's Community Services Worker Abuse Registry, are communicated to OKDHS and the Provider Agency that employs the paid caregiver.

During provider audits, the OKDHS QA staff collects data and forwards a report to Adult Protective Services of all instances of suspected a/n/e that are noted during the audit. If it appears that the member is in a situation of immediate danger, a report is made immediately.

In addition, to information and findings of suspected a/n/e shared with APS, the ADvantage Administration has developed an internal system for prevention and identification of instances of potential a/n/e or concerns for the health and safety of ADvantage Program members. The AA has in place the following mechanisms to safeguard ADvantage Program members.

Service Plan Authorization: Each member's service plan and service plan addenda are reviewed by AA staff prior to authorization. The staff review every member's service plan and other required documentation. Any reference to
involvement of APS or any other concern regarding the member's health and safety requires involvement of the member's case manager for follow up, clarification or additional information prior to authorization of the service plan.

Resource Center/Escalated Issues unit: Reports of or concern about a member's health and welfare are referred to or received by the Resource Center/Escalated Issues unit. Any person can call the 1-800 number -- members, family members, providers, state agencies, or any other individual. The Resource Center/Escalated Issues unit system provides a centralized avenue for responding to inquiries, concerns, and complaints. In the case of suspected abuse, neglect or exploitation, such reports are handled with a sense of urgency and must be escalated to the appropriate Resource Center/Escalated Issues unit supervisory staff for notifying APS immediately. Concerns are documented in the Resource Center/Escalated Issues unit database and categorized under Health and Safety” with a subcategory of either Abuse, Neglect or Exploitation” or Escalated Service Delivery Issue for tracking and resolution.

Provider E-Mail: All ADvantage Program providers may notify the OKDHS ADvantage Administration of potential abuse, neglect and exploitation via e-mail at providerquestions@okdhs.org This system provides easy access for providers to communicate their inquiries, concerns and complaints. Any instance of potential abuse, neglect or exploitation or concerns for the member's health and safety received in this manner are escalated to the appropriate Resource Center/Escalated Issues unit supervisory staff for notifying APS immediately.

Morbidty and Mortality Review (M&M): Clinical review by a Registered Nurse of unexpected deaths or serious physical injury may result in a morbidity and mortality review by AA clinical staff and involve all necessary parties, including provider agencies. The M&M review may result in a Root Cause Analysis (RCA) to determine the primary and secondary causes of such incidents so that individual or system causes can be addressed and corrected.

Conditions of Provider Participation (COPP): These contractual documents with ADvantage Program providers specifically address safety, protection, and welfare of members as well as provider requirements for documenting and reporting abuse, neglect and exploitation.

Provider Performance Audits: The OKDHS conducts onsite provider performance audits and in-home member satisfaction surveys. Audit criteria involves reviewing the member's file for signs of potential abuse, neglect and exploitation as well as observing for such signs while in the member's home.

ADvantage Program Case Management Training: This comprehensive training includes orientation of the member, recognition of abuse, neglect and exploitation and required reporting and monitoring of suspected incidents.

Community Service Worker Registry: According to Oklahoma Administrative Code 340:100-3-30, the Oklahoma Department of Human Services operates a Community Services Registry that allows potential providers and other employers to screen potential employees for offenses involving abuse, neglect and exploitation.

Certified Nurse Aide Registry: The Oklahoma State Department of Health operates a Certified Nurse Aide Registry. According to the OSDH (http://www.health.state.ok.us/program/nrsaid/), “The Nurses Aide Registry serves unlicensed persons and employers of these persons, who provide nursing or nursing-related services to individuals receiving services in long term care facilities, home health agencies, intermediate care facilities for the mentally retarded, residential care facilities, and adult day care centers.”

The mission of the Nurse Aide Registry is to safeguard the health and welfare of Oklahomans by validating conformance to minimum standards, assuring the competency and maintaining a complete listing of all certified nurse aides. The registry includes the following duties related to abuse, neglect and exploitation: “(4) develop and maintain the nurse aide registry; (5) maintain the abuse registry;…(6) provide public education.”

The OKDHS AA provides oversight of the reporting of and response to any critical incidents. AA staff receive provider agency reports of critical incidents and review in accordance with policy. This review of critical incident reports is ongoing and summary reports are compiled monthly.

The AA maintains computer-based systems for storage, retrieval and dissemination of information that supports the ADvantage Program. These systems allow for performance monitoring of members and providers as well as tracking and reporting of complaints related to the health and safety, including abuse, neglect and exploitation. AA departmental managers review reports for trends and follow policies, procedures and business rules for escalation to the appropriate staff, teams, committees or entities as required. This includes review by the AA's Ethics of Care Committee (EOCC). The EOCC reviews trends and prioritizes opportunities for improvement.
Some oversight activities are continuous and ongoing while others have set schedules. Web access to the Community Service Worker Registry and the Certified Nurse Aide Registry are ongoing and continuous for both reporting abuse and for accessing information as to notation of abuse, neglect or exploitation by individual workers. The Resource Center/Escalated Issues unit and Provider Audits offer continuous public access for reporting of abuse, neglect or other health and safety concerns, although staffing for handling messages left by phone (Resource Center/Escalated Issues unit) or via e-mail is 8AM to 5PM weekdays. M& M reviews occur as needed. CM trainings are offered one or more times per month. Service plan reviews and authorizations are annual although review of amendments to add or change a service may occur at any time during the year. Provider Audits and review of COPP occur annually. From each oversight source, information related to abuse, neglect, and exploitation or member health and safety are dealt with first on an individual basis for immediate response; however, information is periodically generated and reported on a provider-specific basis to evaluate whether additional training or intervention with particular providers may be needed.

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:

Adult Protective Services is the designated state agency responsible for investigating any report of unauthorized use of restraints as a form of abuse in accordance with statutory timeframes for such investigations. As noted in Appendix G-1, the Adult Protective Services program is authorized in Title 43A of the Oklahoma Statutes, Sections 10-101 through 10-111. A report can be made to Adult Protective Services 24 hours a day, 365 days a year.

The ADvantage AA has a coordinated system of communication with APS regarding abuse, neglect, and exploitation of any member as part of a comprehensive system-wide critical incident reporting system.

The ADvantage Program has processes to detect the unauthorized use of restraints or seclusion during the delivery of waiver services. These processes include Case Management regular monitoring of the member’s health and welfare, the performance of periodic provider quality reviews including Provider Audits and the incidents reporting system in which restraints or restrictive interventions is a reportable incident.

- 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).

  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:
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:

Adult Protective Services is the designated state agency responsible for investigating any report of unauthorized use of restrictive interventions as a form of abuse in accordance with statutory timeframes for such investigations. As noted in Appendix G-1, the Adult Protective Services program is authorized in Title 43A of the Oklahoma Statutes, Sections 10-101 through 10-111. A report can be made to Adult Protective Services 24 hours a day, 365 days a year.

The ADvantage AA has a coordinated system of communication with APS regarding abuse, neglect, and exploitation of any member as part of a comprehensive system-wide critical incident reporting system.

The ADvantage Program has processes to detect the unauthorized use of restraints or seclusion during the delivery of waiver services. These processes include Case Management regular monitoring of the member's health and welfare, the performance of periodic provider quality reviews including Provider Audits and the incidents reporting system in which restraints or restrictive interventions is a reportable incident.

- 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.

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:

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:

Adult Protective Services is the designated state agency responsible for investigating any report of unauthorized use of seclusion as a form of abuse in accordance with statutory timeframes for such investigations. As noted in Appendix G-1, the Adult Protective Services program is authorized in Title 43A of the Oklahoma Statutes,
Sections 10-101 through 10-111. A report can be made to Adult Protective Services 24 hours a day, 365 days a year.

The ADvantage AA has a coordinated system of communication with APS regarding abuse, neglect, and exploitation of any member as part of a comprehensive system-wide critical incident reporting system.

The ADvantage Program has processes to detect the unauthorized use of restraints or seclusion during the delivery of waiver services. These processes include Case Management regular monitoring of the member's health and welfare, the performance of periodic provider quality reviews including Provider Audits and the incidents reporting system in which restraints or restrictive interventions is a reportable incident.

**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:

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**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.

   Assisted Living Services providers are responsible for monitoring medication regimens for ADvantage participants residing in Assisted Living Centers (ALCs). In accordance with licensure standards, the ALC provider shall have a registered nurse or pharmacist review participant medication regimens monthly and, in addition, have a consultant pharmacist review the medication regimens quarterly. The consultant pharmacist review comprises a section of the quarterly ALC’s Quality Assurance Committee report. The pharmacist reviews and investigates medication problems such as use of contraindicated medications or adverse medication interactions and medication related errors and incidents and reports findings and recommendations through the Quality Assurance Committee to address potentially harmful practices.

   In addition, the ADvantage Case Manager is responsible for ADvantage member assessment, service plan development to meet assessed needs including medication needs and monitoring of service delivery. Monthly, the Case Manager monitors the member’s status and plan authorized service delivery. For members receiving Assisted Living Services which includes medication management and medication assistance, the Case Manager monitors member receipt of medications in accordance with the plan of care.
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.

The Oklahoma State Department of Health (OSDH), the state entity responsible for licensing ALCs, provides follow-up and oversight to ensure participant medications are managed appropriately. The Department conducts unannounced inspections in assisted living centers to determine compliance with state laws and regulations related to medication administration:

OAC 310: 663-19-2 et.al, and OAC 310: 675-9-9.1(c). In addition, rules governing medication staffing found at 310:663-9-2(a) and (b) are ensured through personnel record reviews and interviews with staff.

Regulations at OAC 310: 663-19-1(a) requires centers to record medication errors, and, 310: 663-11-1 and 2 requires the center to monitor trends and incidents at least quarterly.

The annual inspection protocol includes “Task 5 – Medication Administration.” This protocol is utilized to determine whether the center has adopted written policies and procedures to ensure safe administration of medications to residents. The protocol requires the surveyor to review the center’s policies and procedures for safe medication administration, and surveyors directly observe medication administration to determine whether staff adheres to adopted procedures. Surveyors also review incident reports, clinical records and the ALC’s Quality Assurance Committee Pharmacist findings, recommendations and follow-up evaluations to ensure the center has implemented corrective actions when necessary.

Violations of rules are recorded in the survey report provided to the ALC. The center has 10 working days after receipt of the notice of violation to file a plan of correction with the Department (OAC 310: 663-25-4(b)). Within 60 days of the original visit, a revisit survey is conducted to ensure corrective action has successfully removed the deficient practice.

OKDHS, the ADvantage Operating agency has a contract with OSDH for OSDH staff to survey ADvantage Assisted Living applicants for meeting ADvantage standards as part of the ADvantage qualified provider certification process and to include follow-up surveys of ADvantage Assisted Living providers that they continue to meet ADvantage standards as part of the on-going licensing survey reviews of facilities.

The findings from the licensing survey reviews, including medication monitoring findings, are made available to OKDHS within 30 days of survey completion. As these reports are received, OKDHS shares the findings with the QMSC and the OHCA, the Medicaid Agency.

The OSDH medication monitoring gathers information on potentially harmful practices through the medication monitoring survey tools. In addition, the OSDH surveyors review the monthly reports compiled by the Assisted Living consultant pharmacist which documents medication problems such as use of contraindicated medications or adverse medication interactions and medication related errors and incidents. The reports contain both findings and recommendations to the ALC’s Quality Assurance Committee to address potentially harmful practices.

The OSDH reviews medication monitoring survey data to identify harmful practices and to identify trends in practice. The findings are utilized by OSDH to gather information on potentially harmful practices to improve quality of Assisted Living services in the state.

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).

Medication administration
In accordance with OAC 310:663-19-2, each Assisted Living Center (ALC) shall adopt and adhere to written policies and procedures to ensure safe administration of medications to residents. The ALC shall have written policies and procedures for medications administered by ALC staff and by non-ALC personnel. In addition, the ALC shall have policies and procedures that address residents who self-administer medications. The ALC policies and procedures to ensure safe administration of medications shall meet the following minimum requirements:

1. Medications shall be administered only on a physician's order.
2. The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour of administration.
3. An accurate written record of medications administered shall be maintained. The medication record shall include:
   A. The identity and signature of the person administering the medication.
   B. The medication administered within one hour of the scheduled time.
   C. Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method.
   D. Adverse reactions or results.
   E. Injection sites.
   F. An individual inventory record shall be maintained for each Schedule II medication prescribed for a resident.
   G. A resident's adverse reactions shall be reported at once to the attending physician.

An assisted living center may maintain nonprescription drugs for dispensing from a common or bulk supply if all of the following are accomplished:
1. The assisted living center shall have and follow a written policy and procedure to assure safety in dispensing and documenting medications given to each resident.
2. The assisted living center shall maintain records which document the name of the medication acquired, the acquisition date, the amount and the strength received for each medication maintained in bulk.
3. Only a licensed nurse, physician, pharmacist, certified medication aide or medication aide technician may dispense for administration these medications and only upon a physician's written order for as needed or nonscheduled dosage regimens. The physician's written order shall be maintained in the resident's clinical record.
4. Bulk medications shall be stored in the medication area and not in resident rooms.
5. The assisted living center shall maintain records of all bulk medications that are dispensed on an individual signed medication administration record.
6. The assisted living center shall maintain the original label on the container as it comes from the manufacturer or on the unit-of-use or blister package.
7. The assisted living center shall establish in its policy and procedure the maximum size of packaging and shall ensure that each resident receives the correct dosage. The assisted living center shall not acquire nor maintain a liquid medication in a package size that exceeds 16 fluid ounces.
8. An assisted living center shall have only oral analgesics, antacids, and laxatives for bulk dispensing. No other category of medication shall be maintained as bulk medication.

Medication staffing
In accordance with 310:663-9-2, each ALC shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. Unlicensed personnel administering medications shall have completed a certified medication aide or medication aide technician training program that has been reviewed and approved by the Department.

Medication Management Quality Assurance
In accordance with 310:663-11-1, each ALC shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall:
(1) monitor trends and incidents;
(2) monitor customer satisfaction measures; and
(3) document quality assurance efforts and outcomes.

In accordance with 310:663-11-2, the quality assurance committee shall include at least the following:
(1) registered nurse or physician if a medical problem is to be monitored or investigated;
(2) assisted living center administrator;
(3) direct care staff person or staff person who has responsibility for administration of medications; and
(4) pharmacist consultant if a medication problem is to be monitored or investigated.

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:

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

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

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.
  
  Specify the types of medication errors that providers are required to record:

  In accordance with 310:663-19-1, each assisted living center shall record medication errors such as medication given to wrong person, given with no physician’s order on file, wrong dose given, not given within one hour of scheduled time and any adverse reaction to medication whether given appropriately or not. In addition, a resident's adverse reactions shall be reported at once to the attending physician.

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.

The Oklahoma State Department of Health (OSDH), the state entity responsible for licensing ALCs, provides follow-up and oversight to ensure participant medications are managed appropriately. Annually, the Department conducts unannounced inspections in assisted living centers to determine compliance with state laws and regulations related to medication administration: OAC 310: 663-19-2 et.al, and OAC 310: 675-9-9.1(c). In addition, rules governing medication staffing found at 310:663-9-2(a) and (b) are ensured through personnel record reviews and interviews with staff. Regulations at OAC 310: 663-19-1(a) requires centers to record medication errors, and, 310: 663-11-1 and 2 requires the center to monitor trends and incidents at least quarterly.

The annual inspection protocol includes “Task 5 – Medication Administration.” This protocol is utilized to determine whether the center has adopted written policies and procedures to ensure safe administration of medications to residents. The protocol requires the surveyor to review the center’s policies and procedures for safe medication administration, and surveyors directly observe medication administration to determine whether staff adheres to adopted procedures. Surveyors also review incident reports, clinical records and the ALC’s Quality Assurance Committee Pharmacist findings, recommendations and follow-up evaluations to ensure the center has implemented corrective actions when necessary.
Violations of rules are recorded in the survey report provided to the ALC. The center has 10 working days after receipt of the notice of violation to file a plan of correction with the Department (OAC 310:663-25-4(b)). Within 60 days of the original visit, a revisit survey is conducted to ensure corrective action has successfully removed the deficient practice.

The OSDH medication monitoring gathers information on potentially harmful practices through the medication monitoring survey tools. In addition, the OSDH surveyors review the monthly reports compiled by the Assisted Living consultant pharmacist which documents medication problems such as use of contraindicated medications or adverse medication interactions and medication related errors and incidents. The reports contain both findings and recommendations to the ALC’s Quality Assurance Committee to address potentially harmful practices. The OSDH reviews medication monitoring survey data to identify harmful practices and to identify trends in practice. The findings are utilized by OSDH to gather information on potentially harmful practices to improve quality of Assisted Living services in the state.

The findings from the licensing survey reviews, including medication monitoring findings, made available to OKDHS within 30 days of survey completion. As these reports are received, OKDHS shares the findings with the QMSC and OHCA, the Medicaid Agency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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


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 instances of 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 Percentage of member complaints where investigation initiated within required time frame. Numerator: Number of investigations of member complaints initiated within required time frame Denominator: Total number of member complaints

Data Source (Select one):

Other
If ‘Other’ is selected, specify:

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**Performance Measure:**

Number and Percentage of members that receive education on how to report abuse, neglect and exploitation. Numerator: Member records documenting member/family/legal guardian received information and education about how to
recognize and report abuse, neglect and exploitation

**Denominator:** Member records reviewed

**Data Source** (Select one):
- Provider performance monitoring
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Performance Measure:
Number and Percentage of members with report of abuse, neglect and/or exploitation (ANE) for which allegation of ANE was resolved in accordance with state policy and procedure. Numerator: Number of Member APS referral resolved per policy Denominator: Total number of Member APS referrals

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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Performance Measure:
Number and Percentage of Non-ANE Critical Incidents that are appropriately reported and resolved in accordance with policy. Numerator: Number Non-ANE Critical Incidents appropriately reported and resolved in accordance with policy
Denominator: Number of Non-ANE Critical Incidents

Data Source (Select one):
Critical events and incident reports
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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.*

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.*

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

b. Methods for Remediation/Fixing Individual Problems

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

OHCA and OKDHS 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. The OHCA dedicated waiver staff will maintain administrative authority through the use of an electronic database designed for storing information received related to problems identified and resolutions of these matters. The OHCA Director of Waiver Administration and Development will be directly responsible for mediating any individual problems pertaining to administrative authority. The Director of Waiver Administration and Development will work with the designated OKDHS Point of Contact to resolve any problems in a timely manner. Problems requiring system change or additional staff will be addressed through the ADvantage Quality Management Strategies Council (QMSC) which may form workgroups involving appropriate personnel to resolve issues more timely and effectively or to initiate systemic changes to address re-occurring issues/performance failures. These problems and resolutions will also be reported in the LTCQIC meetings.

Individual problems may be discovered during monitoring activities by the State or by any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring are described in each performance measure of this appendix.

If as part of remediation, a corrective action plan is required, the plan will detail the steps to be taken to prevent future performance failures along with the timeframe, not to exceed 30 days, for implementation of the corrective actions. Any performance failures, or remediation corrective actions, that may result in a loss of eligibility or reduction of services for one or more individual members will be referred to the EOCC for appropriate follow-up to safeguard the health and safety of members affected.

The options for remediation of Health and Welfare assurances performance failures are listed below:

Remediation for Health and Welfare Assurances:

- Number and Percentage of members that receive education on how to report abuse, neglect and exploitation.
- Number and Percentage of member complaints where investigation initiated within required time frame.
- Number and Percentage of members with report of abuse, neglect and/or exploitation (ANE) for which allegation of ANE was resolved in accordance with state policy and procedure.
- Number and Percentage of Critical Incidents that are appropriately reported and resolved in accordance with policy.

The OKDHS Provider Audit Unit monitors that members received education from Case Managers on how to report abuse, neglect and exploitation. If any instances are found that a member has not received education on how to report abuse, neglect and exploitation, the OKDHS HCBS Quality Assurance Manager provides to the Case Management Provider a final audit report that includes information regarding this deficiency that requires a corrective action plan. The agency is given 30 days to submit the corrective action plan which must address this education failure and must include immediate resolution for members that are still active. Providers operating under corrective action plans are required to submit monthly Progress Reports for 4 months to the Quality Assurance Manager. At the conclusion of a corrective action cycle, the OKDHS Provider Audit unit performs a follow up audit of the Provider.

OKDHS Resource Center/Escalated Issues unit staff monitors that all member complaint investigations were initiated within required time frame, that all allegations of member abuse, neglect and/or exploitation were resolved in accordance with state policy and that all critical incidents were appropriately reported and resolved in accordance with policy. For any circumstance in which a member’s health or safety is at risk,
within one day the Escalated Issues unit staff initiates planning with the member, the Case Manager, Adult Protective Services and others to facilitate member safeguard in existing environment or relocation to a safer living arrangement and/or transfer to a different service provider, as the situation may warrant. If any instances are found in which a complaint investigation was not initiated within required time frame, an allegation of member abuse, neglect and/or exploitation was not resolved in accordance with policy, or a critical incident was not reported and/or resolved in accordance with policy, the OKDHS ADvantage Programs Assistant Administrator for Provider/Client Relations contacts directly for resolution the Provider and/or appropriate OKDHS staff and, if deemed necessary, the Programs Assistant Administrator for Provider/Client Relations will be required to submit, within five working days of request, a corrective action plan to the Programs Administrator of the ADvantage Administration Unit.

Quarterly, OKDHS will provide reports of remediation and corrective action plans (if any) to the ADvantage QMSC and to the OHCA Director of Waiver Administration and Development.

### ii. Remediation Data Aggregation

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

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### 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 2)

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;
- 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 2)

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.

The Quality Management Strategy Council (QMSC) collaborates for the trending, prioritizing and implementation of system improvement. The Council consists of Executive staff and Quality Assurance/Quality Improvement leadership from OHCA, OKDHS and the LTCA of Enid. 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 performance and key indicator reports prepared by OHCA, OKDHS and the FMS sub-agent. 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 in collaboration with the Long Term Supports and Services Council (LTSSC). The LTSSC consists of the QMSC members plus the Director of OHCA Opportunities for Living Life Division (OLL), the OKDHS
Director of Aging Services Division, the OKDHS Chief Executive Officer of Vertically Integrated Services, and a representative of OKDHS, Family Support Services Division.

The ADvantage Quality Management Strategy weaves together various quality assurance and quality improvement activities using a three-tiered process:

TIER 1: The first tier involves strategies to ensure service members, advocates, Case Managers, Interdisciplinary Service Planning teams and providers have the tools to develop, implement and monitor quality services. At this level, quality assurance and improvement happens with service members on an ongoing basis and is designed to safeguard service members.

Tier 1 Quality Assurance Processes:

- Provider training
- Case Management supervision and training
- Individual Service Plan development
- Health and Safety Reviews
- Case management monitoring, coordination and reviews
- Grievance procedures
- Fair Hearing procedures
- Community Services Worker pre-employment screenings
- Community Services Worker Registry pre-employment screenings
- OSBI Criminal Background pre-employment screenings
- Critical Incident System
- Area and Provider Emergency On-Call Systems

TIER 2: The second tier involves OKDHS AAU Programs Administrators, the OKDHS Level of Care Determination Unit Nurse Programs Administrators, the OHCA Audit and Program Integrity Management Division and the OKDHS Provider Audit 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, advocates, service 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 2 Discovery and Remediation Processes:

- Administrative Inquiries
- Ethic of Care Committee (EOCC) reviews including Critical Incident Reviews
- Consumer Satisfaction Surveys
- Data extracts from plan of care authorization database and paid claims history
- WMIS database reports
- CMS Assurances Performance Measures and Remediation reports
- OHCA Surveillance and Utilization Review Systems
- OHCA Audit and Management Division retrospective audit reviews
- Provider monitoring

TIER 3: The third tier involves OKDHS AAU Executive and State Office Executive staff and OHCA OLL Waiver Administration and Development staff. A Quality Management Strategy Council reviews findings and activities from Tier 2. The Council develops strategies for system improvement, establishes priorities, compiles and communicates Quality Management Reports and evaluates and revises the Quality Management Strategy annually.

Tier 3 Quality Management Process:

- Compile and analyze Tier 2 activities
- Develop and prioritize system improvement strategies
- Publish Annual Report
- Complete Annual Quality Management Strategy Review and Revision

Effective compilation and communication of quality management information requires an appropriate...
infrastructure that is designed for that purpose. The backbone of support for ADvantage Quality Improvement Strategy (QIS) consists of three integrated relational databases and their associated subsystems for criteria-based evaluation and output systems for report/notification – MMIS, ELDERS and WMIS.

Monthly, OKDHS generates the ADvantage Cumulative Report which reports key demographic and process program measures. The report is distributed to administrative leadership within OKDHS, OHCA and to representatives of Member advocacy and Provider groups.

Quarterly the ADvantage QMSC reviews system quality assessment reports and may develop recommendations for revision and/or addition of system quality monitoring and/or improvement projects. Annually, all QMSC system changes are incorporated into the QIS description that is filed as part of the 372 reporting cycle for the waiver.

Comparative data that is gleaned from MMIS, WMIS and ELDERS is evaluated by the QMSC, and by the LTSSC to determine if system changes are warranted. Review of these reports may also lead to initiation of new improvement projects to benefit waiver members.

The following general processes and criteria guide the setting of priorities in implementing system improvements:

Prioritization

The ADvantage Program prioritizes quality improvement activities and projects from those opportunities that provide the most benefit to the member, the community, stakeholders, system, organization, and funding entities, at the same time maximizing use of quality improvement resources. Consideration is given to the issues based on the following criteria:

1) Regulatory Requirements - required by law or funding sources;
2) High Risk - likelihood of adverse events or outcomes;
3) High Volume - affects many individuals;
4) High Cost - causes financial drain on system;
5) High Impact - potential to make significant change;
6) High Likelihood of Success - easy to implement and provides successful outcome;
7) Problem Prone - causes major problems if it occurs;
8) Feasibility of Time and Resources - cost/staff commitment required;
9) Measurability - data and resources can capture necessary information; and
10) Readiness to Address Issue - the time, situation, and climate are right.

After the QMSC has identified a need for system improvement and decided action is needed, the design and development of the processes for implementing the system improvement is accomplished by the administrative unit that is responsible for the ADvantage administrative function working in concert with a QMSC subcommittee created to advise and track progress of the implementation of the systems improvement project.

Progress on system improvement projects are reported during QMSC and LTSSC quarterly meetings and shared with unit Program Administrators, providers and other stakeholders with primary interest in the area targeted for improvement efforts. System improvement projects and project status or outcomes are included in the ADvantage Annual Report on Quality. This report is distributed to interested parties including the OHCA Board and Human Services Commission, members of the state legislature, and is posted on the OHCA and OKDHS websites for access by service members and their families, advocates, and members of the general public.

### ii. System Improvement Activities

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**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.

In addition to tracking and evaluating performance measures and other key indicators of quality for established functions, the QMSC likewise tracks and assesses system improvement projects and system design changes. These changes may evolve from analysis and evaluation of evidence discovered through performance measure trends or from remediation detail or reoccurring root causes of failures leading to remediation. Or they may derive from other key quality indicators such as particular issues prompting one or more fair hearings, etc.

For each system improvement project or system design change, the QMSC creates a subcommittee to track the progress of the improvement/change implementation and to measure outcomes related to that change. Since each improvement/change derives from informed evaluation of a prior condition related to quality of service/function, measures are derived, if not already existing, from the past and current condition to serve as a baseline for future evaluation of improvement/change impact.

The QMSC design improvement subcommittee consults with administrative program staff of the unit responsible for implementing the improvement/design change and for collecting performance measures post design change. During the process of measure definition, the subcommittee determines sources of data and whether data collection for the measure will be based upon 100% or a random sample and the frequency of data aggregation/analysis/reporting. In addition, the subcommittee in consultation with the administrative unit determines the time-frame during which a meaningful and measurable change in quality can reasonably be expected after implementation of the system improvement/change. The measures, data sources, sampling and reporting procedures will be evaluated and approved the design improvement subcommittee prior to improvement design change implementation. The chairperson of the design improvement subcommittee will present a summary of the improvement design change, measures for tracking design change impact and procedures for data collection and analysis to the QMSC during quarterly meetings.

The QMSC discusses and evaluates the trends and documented progress or lack of progress in quality being addressed by the improvement/design change. After the time period initially projected to be reasonably sufficient to detect a beneficial change has elapsed, the QMSC formally evaluates progress and determines whether the improvement/change appears to be achieving its objective or whether more time may be needed to determine success or whether some tweaking of the implementation strategy may be needed or whether the effort has clearly failed and a different approach needs to be considered. If the effort appears to be succeeding, the improvement/change is formally evaluated again after a total elapsed time period that is double the initial projected time-frame projected to be sufficient to detect a beneficial impact. At this second evaluation a determination will be made as to the improvement/design change success and if not successful, what different approach could be taken to achieve improvement. With adoption of a different improvement/design change implementation, the cycle is repeated.

The QMSC reports system improvement/design change projects and outcomes during its regular meetings and distributes and discusses these reports during LTSSC meetings. In turn these reports are shared with administrative unit leads and with stakeholders directly involved in the system change effort. In addition, the QMSC describes and summarizes all system improvement/design change projects and outcomes in the ADvantage Annual Report on Quality. This report is distributed to interested parties including the OHCA Board and Human Services Commission, members of the state legislature, and is posted on the OHCA and...
OKDHS websites for access by service members and their families, advocates, and members of the general public.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Management Strategy Council (QMSC) meets quarterly to review and analyze information from the previous quarters and to review progress of system improvement projects. Quality measure trends and issues are presented, discussed, and evaluated to inform decisions on additional actions to improve quality. The QMSC periodically reviews and evaluates the QIS performance measures, sampling strategies, and processes for remediation and improvement. The evaluation compares performance to anticipated benchmark performance, analyzes trends in performance improvement/decrement, and analyzes remediation reports to identify systemic failures and reviews reports and descriptions of best-practice quality improvement approaches from other states for applicable practice to addressing performance issues in ADvantage. Based upon evaluation, the QMSC may identify areas in need of improvement and decide upon modification to existing strategies or development and implementation of additional improvement strategies. The QMSC evaluates the Quality Management Strategy at least annually and revises it as necessary.

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).

(a) The Operating Agency AA performs a financial assessment of the waiver service providers as part of a more comprehensive provider certification/annual recertification process. The financial assessment reviews end of year financial statements (liabilities, assets & equity “balance sheet”) for the most recently completed fiscal year of operation. In addition, OHCA Program Integrity and Accountability conducts audits on waiver services.

(b) Errors in provider claims include (1) claims payment without corresponding documentation of service delivery and (2) claims payment in excess of service plan authorization. Claims error incidence will be measured for each member and in summary of all members reviewed. Measures of claims error incidence 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. Discovery Method: For the provider financial audit, members are selected at random for the programmatic review. All claims for services delivered to them over a one quarter period are reviewed. Frequency: Annually Entity Responsible for Reviewing Findings: OHCA Provider Audit Team Communication: Report of financial audit to provider includes findings and recommendations/requirements for plan of correction/interaction of provider business process, if any. Prevalence 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 provider's billing practices.

(c) OHCA Program Integrity and Accountability is responsible for conducting financial audits.

(d) The entity that is responsible for the independent audit under the Single Audit Act in Oklahoma is the Office of the State Auditor and Inspector. This agency performs annual audits separately and apart from the operating agency (OKDHS) and the Medicaid agency (OHCA.)

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (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 Percentage of claims paid in accordance with waiver reimbursement methodology. Numerator: Number of ADvantage claims paid in accordance with waiver reimbursement methodology Denominator: Number of ADvantage claims paid

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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Performance Measure:
Number and percentage waiver claims paid for members enrolled in the waiver on the date that the service was delivered. Numerator: Paid claims for ADvantage services to members enrolled in the waiver. Denominator: Paid claims for ADvantage waiver services

Data Source (Select one):
Financial records (including expenditures)
If ‘Other’ is selected, specify:

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Performance Measure:
Number and percentage provider financial management and recordkeeping processes operational and current. Numerator: Total provider financial management and recordkeeping processes operational and current. Denominator: Total required financial management and recordkeeping processes operational and current.

Data Source (Select one):
Financial records (including expenditures)
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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.

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

b. Methods for Remediation/Fixing Individual Problems

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

OHCA and OKDHS 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. The OHCA dedicated waiver staff will maintain administrative authority through the use of an electronic database designed for storing information received related to problems identified and resolutions of these matters. The OHCA Director of Waiver Administration and Development will be directly responsible for mediating any individual problems pertaining to administrative authority. The Director of Waiver Administration and Development will work with the designated OKDHS Point of Contact to resolve any problems in a timely manner. Problems requiring system change or additional staff will be addressed through the ADvantage Quality Management Strategies Council (QMSC) which may form workgroups involving appropriate personnel to resolve issues more timely and effectively or to initiate systemic changes to address re-occurring issues/performance failures. These problems and resolutions will also be reported in the LTCQIC meetings.

Individual problems may be discovered during monitoring activities by the State or by any of the entities that have been delegated certain functions within the performance measures of this appendix. Those responsible for conducting the monitoring are described in each performance measure of this appendix.

If as part of remediation, a corrective action plan is required, the plan will detail the steps to be taken to prevent future performance failures along with the timeframe, not to exceed 30 days, for implementation of the corrective actions. Any performance failures, or remediation corrective actions, that may result in a loss of eligibility or reduction of services for one or more individual members will be referred to the EOCC for appropriate follow-up to safeguard the health and safety of members affected.

The options for remediation of Financial Accountability assurances performance failures are listed below:

Remediation for Financial Accountability Assurances:

• Number and Percentage of claims paid in accordance with waiver reimbursement methodology
• Number and percentage waiver claims paid for members enrolled in the waiver on the date that the service was delivered

The OHCA Program Integrity and Accountability Unit monitors that ADvantage member claims are paid in accordance with waiver policy and that claims only for members enrolled when services are delivered. If any instances are found that a claim has been paid inappropriately either due to not being in accordance with approved reimbursement methodology or for services delivered to a non-enrolled member, the OHCA Director of Program Integrity and Accountability contacts directly for resolution the appropriate OHCA staff and, if deemed necessary, the Director of Program Integrity and Accountability will be required to submit, within five working days of request, a corrective action plan to the Director of Waiver Administration and Development. Any reimbursement for claims found to have been inappropriately paid are recouped from providers.
Quarterly, OKDHS will provide reports of remediation and corrective action plans (if any) to the ADvantage QMSC and to the OHCA Director of Waiver Administration and Development.

ii. Remediation Data Aggregation

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

<table>
<thead>
<tr>
<th>Responsible Party (check each that applies):</th>
<th>Frequency of data aggregation and analysis (check each that applies):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ State Medicaid Agency</td>
<td>☑ Weekly</td>
</tr>
<tr>
<td>☐ Operating Agency</td>
<td>☑ Monthly</td>
</tr>
<tr>
<td>☐ Sub-State Entity</td>
<td>☑ Quarterly</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☑ Annually</td>
</tr>
<tr>
<td>Specify:</td>
<td>☑ Continuously and Ongoing</td>
</tr>
<tr>
<td>☐ Other</td>
<td>Specify:</td>
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</tbody>
</table>

- **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).

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.

All services and associated rates are accessible to the general public through publication on the OHCA and OKDHS websites.

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

1) **Method One -Utilizing the Medicaid Rate:** When a waiver service is similar or the same as a Medicaid service for which a fee schedule has been established, the current Medicaid rate is utilized. Examples of these services include:
   a) Facility Based Respite Care: Reimbursement for this service is made at the current daily level of care nursing facility rate for intermediate care (ICF).
b) Personal Care Services: Payment is made at the rate established for State Plan Personal Care services.
c) Respite in the Home: Payment is made at the rate established for State Plan Personal Care services.
d) Prescription Drugs: Payment is made at the rate established for drugs paid for under the State Plan.

2) Method Two - Utilizing the current Medicare Rate: When the waiver service mirrors an existing Medicare service the current Medicare rate is utilized.

3) Method Three - 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, members, 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 the Department of Human Services (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.

f) ADvantage services set by fixed, uniform rate setting are:
   i) Case Management
   ii) Nursing
   iii) Therapy Services
   iv) Adult Day Health Care
   v) Home Delivered Meals
   vi) Advance Supportive/Restorative Assistance
   vii) Personal Emergency Response System
   viii) Medical Equipment and Supplies
   ix) Assisted Living Services
   x) Hospice.
   xi) Skilled Nursing

4) Individual Rates: 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. Examples of these services, include:
   a. Architectural Modifications Methodology for these rates varies for different providers according to actual provider specialty. Providers may include Architects; Electricians; Engineers; Mechanical Contractors; Plumbers; Remodelers and Builders. Further, each required environmental modification is different. For example, ramps costs (due to the initial conditions of the home and yard) differ according to such variables as the length of the ramp, types of rails, and strength of the ramp needed if, for instance the member has an electric wheelchair.
   b. Consumer-Directed Personal Supports and Services Methodology for these rates includes an analysis of the comparable payments to agencies. A range of payments per hour is calculated for member consideration when hiring the member-directed personal or advanced care provider. This provides the member the flexibility as employer to pay different salaries to different workers within programmed defined limits.
   c. Personal Emergency Response Systems vary depending on the location and the provider.
   d. Specialized Medical Equipment and Supplies are authorized by selecting the best bid from among a minimum of three, except for incontinence supplies. Incontinence supplies are reimbursed based on fixed rates that were established based on a study of Oklahoma and 24 other states’ payments and providers’ costs.
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:

Provider claims for waiver services are filed directly with the OHCA fiscal agent, Hewlett Packard (HP). Claims are adjudicated through Oklahoma’s CMS-certified MMIS. All waiver services require prior authorization. Prior authorizations are generated from the waiver member’s individual treatment plan. The prior authorization is in the MMIS. All transactions are HIPAA compliant and secure.

**Appendix I: Financial Accountability**

**I-2: Rates, Billing and Claims (2 of 3)**

c. **Certifying Public Expenditures** *(select one):*

- ☐ No. State or local government agencies do not certify expenditures for waiver services.
- ☐ Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

*Select at least one:*

- ☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

  Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

- ☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

  Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

**Appendix I: Financial Accountability**

**I-2: Rates, Billing and Claims (3 of 3)**

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant’s approved service plan; and, (c) the services were provided:

Claims for waiver services are processed by Oklahoma’s CMS-certified MMIS and are subject to all validation procedures included in the MMIS. This ensures that payments are made only when:

(a) All claims for waiver members are first validated for member eligibility according to data contained in the MMIS.

(b) All claims for waiver services must be matched to an active prior authorization. Prior authorizations are created from the waiver member’s 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 (see Appendix I-1) 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 Program Integrity and Accountability for review and further investigation of the provider’s billing practices.

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:

The FMS receives payment as the limited fiscal agent for self-directed services. Services that can be self-directed include: CD-PASS Personal Services Assistance and Advance Personal Services Assistance. The limited Fiscal Agent performs the following functions:

1. Assists member in verifying support worker citizen status,
2. Collects and processes timesheets of support workers,
3. Processes payroll, withholding, filing and payment of applicable federal, state and local employment related taxes and insurance.

In addition, according to the needs and desires of the member the FMS may provide orientation and training regarding employer responsibilities as well employer information and management guidelines, materials, tools and staff consultant expertise to support and assist the member in successfully performing employer-related functions. OKDHS is IRS fiscal agent and has direct contract monitor responsibility for overseeing the operations of the limited fiscal sub-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:

The University of Oklahoma College of Nursing and several local Council of Governments provide Case Management services for individuals enrolled in the Advantage Waiver.

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:

- 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. Select one:

☐ 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.
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
- [X] Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

State share funding for services provided under all of Oklahoma’s HCBS Waiver Programs is from General Fund Appropriations from the State Legislature made to two (2) State Agencies. The OKDHS 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 OKDHS for the State share dollars for all Waiver services (except “prescription drugs”) for which provider claims were processed/paid. Through an inter-Agency transfer, these State share funds are then deposited into the OHCA’s general fund. The transfer of these funds represents a repayment to the OHCA, since the OHCA 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:

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:

Assisted Living Services Reimbursement Rate Determination

The only residential facilities in which ADvantage members are allowed to receive services (other than respite in a NF) are Assisted Living Centers approved to provide ADvantage Assisted Living services. In these circumstances, Assisted Living Services reimbursement rates are determined solely on costs of services and exclude room and board costs which are paid for separately by the member.

The reimbursement rate for Assisted Living services follows three service need-based tiers with providers reimbursed at the tier the member is assessed to need. The cost for room with associated facility utility and maintenance costs and the cost for food for meals have been excluded from these reimbursement rates. The following guidelines were used when developing the provider rates:

• Room and board costs are excluded from provider reimbursement rate determination;
• Only costs for ADvantage Assisted Living services are considered in development of reimbursement rate;
• The reimbursement rate needs to be attractive enough to encourage providers to participate;
The rate needs to reimburse Assisted Living Services providers at a level adequate to support staffing capacity required to provide quality care and 24 hour staffing;

The reimbursement rate needs to be realistically determined taking into consideration the varying need levels of members with ADLs and IADLs as well as specialized care related to daily medical needs, and;

The reimbursement rate for Assisted Living Services needs to be established so that, even at the highest tier of reimbursement, there is a reasonable expectation that a service plan can be developed to meet a member’s additional ADvantage service needs within the cost constraints of the waiver.

Room and Board Payments:
Members will pay their room and board expenses directly to the Assisted Living Center, which will determine the room and board charge. The ADvantage Assisted Living provider is required to execute an Admission Agreement with each ADvantage member and is prohibited from modifying the room and board charge without providing at least 30 days prior written notice to the member.

Minimally, members receiving ADvantage services in the Assisted Living setting will have an income comprised of SSI and State Supplemental Payment (SSP) available to pay for room and board. If the member is an SSI recipient ADvantage rules restrict the allowable maximum room and board charges to be equal to the SSI payment.

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 1-7-a-ii through 1-7-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 waiver recipients are subject to a co-payment on prescription drugs unless the individual recipient 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.

<table>
<thead>
<tr>
<th>Waiver Service</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed Drugs</td>
<td><strong>Amount:</strong>&lt;br&gt;$0.00 for preferred generics.&lt;br&gt;$0.65 for cost of $0.00-$10.00&lt;br&gt;$1.20 for cost of $10.01-$25.00&lt;br&gt;$2.40 for cost of $25.01-$50.00&lt;br&gt;$3.50 for cost of $50.01 or more</td>
</tr>
<tr>
<td></td>
<td><strong>Basis:</strong>&lt;br&gt;$0.00 for preferred generics.&lt;br&gt;$0.65 for prescriptions having a Medicaid allowable payment of $0.00-$10.00.&lt;br&gt;$1.20 for prescriptions having a Medicaid allowable payment of $10.01-$25.00.&lt;br&gt;$2.40 for prescriptions having a Medicaid allowable payment of $25.01-$50.00 and $3.50 for prescriptions having a Medicaid allowable payment of $50.01 or more. Co-payments are for members 21 and older.</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Year</th>
<th>Factor D</th>
<th>Factor D'</th>
<th>Total: D+D'</th>
<th>Factor G</th>
<th>Factor G'</th>
<th>Total: G+G'</th>
<th>Difference (Col 7 less Column 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9224.56</td>
<td>5882.67</td>
<td>15107.23</td>
<td>29827.65</td>
<td>3211.40</td>
<td>33039.05</td>
<td>17931.82</td>
</tr>
<tr>
<td>2</td>
<td>9517.39</td>
<td>6129.74</td>
<td>15647.13</td>
<td>31945.42</td>
<td>3211.40</td>
<td>35156.82</td>
<td>19509.69</td>
</tr>
</tbody>
</table>
### 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>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Unduplicated Number of Participants (from Item B-3-a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>22021</td>
<td>22021</td>
</tr>
<tr>
<td>Year 2</td>
<td>22731</td>
<td>22731</td>
</tr>
<tr>
<td>Year 3</td>
<td>23615</td>
<td>23615</td>
</tr>
<tr>
<td>Year 4</td>
<td>24337</td>
<td>24337</td>
</tr>
<tr>
<td>Year 5</td>
<td>24895</td>
<td>24895</td>
</tr>
</tbody>
</table>

#### Table: J-2-a: Unduplicated Participants

<table>
<thead>
<tr>
<th>Level of Care:</th>
<th>Nursing Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Unduplicated</td>
<td></td>
</tr>
<tr>
<td>Number of</td>
<td></td>
</tr>
<tr>
<td>Participants</td>
<td></td>
</tr>
</tbody>
</table>

#### 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 rationale for average length of stay (ALOS) calculations is described below.

The number of participants in the waiver at the beginning of the first month of the first waiver year is estimated. This estimate is based upon the number persons being served during the last year of the previous waiver cycle when the estimate is calculated. The calculation takes into account the history of entries into and exits from the waiver during that year and projects the number of participants anticipated at the beginning of the new waiver year.

Based upon the most recent waiver year, the number of entries and exits per month are used to project growth and turnover of participants during future waiver years. For each month of each waiver year the total days served is calculated as follows:

- Waiver clients are served for the entire month if they are in the waiver at the START of a month and do not DEPART during the month;
- Therefore, waiver clients served in the waiver the entire month equals the START number minus the DEPART number;
- 365/12 = 30.4 days is the estimate for the # of days a waiver client is served in an average month when the client is in the waiver the entire month;
- Waiver clients served for only part of a month are clients who either enter the waiver during the month (the ADD number) or DEPART from the waiver during the month;
- Therefore, the total number of waiver clients served in the waiver for part of each month is the sum of the ADDs and DEPARTs during that month (this estimate assumes there are no duplicates across the ADDs and DEPARTs);
- A person that ADDs to the waiver or DEPARTs from the waiver during a month may enter on the first day or the last day or on any day in between;
• Lacking other information, the best estimate of central tendency across a set of values is the midpoint or average of the set of values;
• Therefore, the estimate of the average number of days served in the waiver by ADDs and DEPARTs is the average or midpoint of all possible number of days of service in an average month of 30.4 days, which is 30.4 divided by 2 equals 15.2 days;
• Total Days served in a month = [(START #) - (DEPART #)] x 30.4 days] + [(ADD # + DEPART #) x 15.2 days]

Using the first month of the first waiver year as an example, total days for the month are determined in accordance with the following table and previously described calculations.

Example:

MONTH START ADD DEPART END TOTAL DAYS
1 17,221 400 362 17,259 524,096

Days for clients in the waiver the entire month = [(START #) - (DEPART #) x 30.4 days]
= (17,221– 362) x 30.4 days
= 16,859 x 30.4 days
= 512,513.6 days

Days for clients in the waiver part of the month = [(ADD #) + (DEPART #) x 15.2 days]
= (600 + 327) x 15.2 days
= 927 x 15.2 days
= 11,582.4 days

Total Days served in month = [(START #) - (DEPART #)] x 30.4 days] + [(ADD # + DEPART #) x 15.2 days]
= 512,513.6 days + 11,582.4 days
= 524,096.0 days
= 524,096 days rounded to nearest whole day

For the entire year, total clients, total days and average length of stay is determined in accordance with the following table and previously described calculations:

WAIVER RENEWAL YEAR 1  2011 - 2012
Oklahoma's Statewide A/D Medicaid Waiver

MONTH START ADD DEPART END TOTAL DAYS
1 17,221 400 362 17,259 524,096
2 17,259 400 362 17,297 525,251
3 17,297 400 363 17,334 526,391
4 17,334 400 364 17,370 527,501
5 17,370 400 365 17,405 528,580
6 17,405 400 366 17,439 529,629
7 17,439 400 366 17,473 530,662
8 17,473 400 367 17,506 531,681
9 17,506 400 368 17,538 532,669
10 17,538 400 368 17,570 533,642
11 17,570 400 369 17,601 534,599
12 17,601 400 370 17,631 535,526
TOTAL 22,021 4,800 4,390 6,360,227

The Add per month number is the estimated number anticipated to enter the waiver program each month. The Depart per month is equal to 2.1% of the number in the program at the start of each month which has been the average historical departure rate.

Total clients served are the number of clients at the Start of the year plus the number Added during the year (17,221
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 for these estimates is as follows:

Waiver Service – The waiver service as defined in Appendix C-3 of this waiver document.

Unit (Column 1) — The unit quantity for the service in time or number of items as defined on the Oklahoma MMIS.

# Users (Column 2) — The total estimated number of unduplicated Medicaid Users of the specified waiver service over the indicated one year period of waiver operation. For all services except CD-PASS, this number is based on the percentage of users of each service based upon waiver year 2010, the most recent year for which complete 372(S) data was available. The total number of unduplicated users was multiplied by the appropriate percent of consumers using each service in FY2010 to derive the estimated number of users of each service in each year.

There are two exceptions to the previously stated general rule for computation of number of users per service – users of Assisted Living Services and of CD-PASS services. The Assisted Living Services began serving in FY2010 and we anticipate significant growth in utilization for this service over the next three years. For the CD-PASS service, the number of users per year is equal to the estimate provided on item n. “Goals for Participant Direction” in Appendix E-1 associated with anticipated expansion of this service to other geographic areas of the state. In addition, in each year of CD-PASS expansion, a slight reduction in utilization of ADvantage Personal Care has been figured into the estimate for users of ADvantage Personal Care.

Average Units/User (Column 3) — The average number of projected (ALOS Adjusted) Units per Year for the service for users receiving that service. For all services in Year 1, the average Units/User estimate is based on waiver year 2010, the most recent year for which complete 372(S) data was available. Multiplying 2010 Average Units/User by the ALOS for the waiver year divided by 2010 ALOS achieves the ALOS adjustment for Waiver Renewal year 1. For waiver years after year 1, the ALOS adjustment is computed as the current waiver year ALOS divided by the previous year ALOS times the previous year Average Units/User rounded to the nearest whole unit.

Average Cost/Unit (Column 4) — The estimated cost for each unit of service delivered. For 2012 (Renewal Year 1), for each service, the average cost/unit is based upon the cost/unit in waiver year 2010, the most recent year for which complete 372(S) data was available adjusted for one year of rate anticipated increase based upon individual per unit cost increase for each service based upon claims data history of average per unit rate increase. For each successive waiver year, the cost per unit is adjusted based upon this inflation factor. The specific cost per unit per year inflation factors used are listed in descending order as follows:

- Prescription Drugs 3.1%
- Nursing 8.9%
- Environmental Modifications 7.1%
- Adult Day Care 6.2%
- Hospice 4.0%
- Case Management 3.5%
- Personal Care 2.3%
- Advanced Supportive/Restorative 2.1%
- Meals 1.8%
- PERS 1.0%
- Equipment & Supplies 0.0%
- Therapy Services 0.0%
Services of Respite, Assisted Living and CD-PASS are linked in rate setting to Personal Care and are therefore anticipated to have an average cost per unit increase at 2.3% the same as for Personal Care.

For waiver years 3, 4 and 5, the basis for Factor D estimates have been revised as follows:

# Users (Column 2) — The number of members requiring the added extended State Plan Service of Skilled Nursing was estimated from an analysis of members who had exhausted the State Plan Home Health benefit services in waiver Year 1 that from record review would have benefited from delivery of additional in-home Skilled Nursing services.

Average Units/User (Column 3) — The average units per user of Skilled Nursing was estimated from an analysis of members who had exhausted the State Plan Home Health benefit services in waiver Year 1 along with an evaluation and estimate by AAU Nursing staff of the number of additional units that they required for skilled nurse treatment of injury or disease. The average number of units per user of Adult Day Health services was increased related to the increase in maximum units per day requested in this waiver amendment and based upon data obtained from providers of number of members and additional units of Adult Day Health required to meet member needs.

Average Cost/Unit (Column 4) — In waiver year 3, the average cost/unit was adjusted to reflect actual rates of services anticipated to be effective at the start of waiver year 3. With the economic downturn, service rates have not increased in line with historical trends and no rate increases have occurred in several years until a recently approved rate increase that will be applied to several services effective the beginning of waiver year 3. Except for Therapy Services, the inflation factors previously used are applied to estimates of average cost per unit in years 4 and 5. Therapy Services were excluded from estimates of increased service cost per unit in years 4 and 5 because these services received a very significant rate increase (45.5%) that begins in waiver year 3 and are not anticipated to have additional rate increases until the next waiver renewal cycle.

**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:

ADvantage State Plan Services Utilization and Expenditures
Based on CMS-372 Reports 2007-2010

In the several years prior to waiver year 2007, State Plan Services utilization and cost data variations were driven primarily by major program policy changes with respect to prescription drugs, particularly implementation of Medicare Part D. In 2006, the average cost for an ADvantage member for State Plan Services was $5,574 – about $600 more than total cost in 2007. All of this cost reduction was due to reduced drug costs. Since 2007 State Plan costs seem to have been driven by changes due to inflation and utilization. Consequently 2007 is being used as the base year from which to calculate average yearly increase in Factor D’.

Fiscal Year

Clients

Total Expenditures

Average Cost
2007 19,106 $103,186,421 $4,818
2008 21,416 $121,968,734 $5,195
2009 24,084 $129,004,242 $5,356
2010 22,790 $123,472,280 $5,418

The average percent increase in ADvantage State Plan services costs from 2007 to 2010 is 4.2% per year. For 2012 (Renewal Year 1), the average ADvantage State Plan services cost is based upon the average ADvantage State Plan services cost in waiver year 2010, the most recent year for which complete 372(S) data was available, adjusted for one year of anticipated average cost increase based upon average cost increases over the prior four year period using the inflation factor of 4.2% increase per year. Similarly for waiver years 2 through 5, the prior year D’ Factor is multiplied by 1.042 to derive the estimate of State Plan Services costs in each year.
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:

Nursing Facility Utilization and Expenditures  
Based on CMS-372 Reports 2006-2010  

Fiscal Year Recipients Expenditures Average Cost  
2006 20,963 $425,189,388 $20,283  
2007 20,458 $474,819,853 $23,209  
2008 20,261 $497,787,282 $24,569  
2009 19,629 $504,368,697 $25,695  
2010 19,257 $500,766,809 $26,004  

Based on CMS-372 data, average cost of NF care increased $5,721 from 2006 to 2010. The average percent increase per year in average Oklahoma Medicaid NF cost from 2006 to 2010 is 7.1%.

For 2012 (Renewal Year 1), the average NF cost is based upon the NF cost in waiver year 2010, the most recent year for which complete 372(S) data was available, adjusted for one year of anticipated average cost increase based upon average cost increases over the prior five year period. For FY2012, the estimate of Factor G is $29,828. For each successive waiver year, the NF average cost (G Factor) is adjusted based upon this annual 7.1% average cost inflation rate.

For renewal years 1 - 5 of the ADvantage waiver, Factor G is estimated to increase by a factor of 1.071 for each consecutive year.

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:

Nursing Facility State Plan Services Utilization and Expenditures  
Based on CMS-372 Reports 2007-2010  

In the several years prior to waiver year 2007, State Plan Services utilization and cost data variations were driven primarily by major program policy changes with respect to prescription drugs, particularly implementation of Medicare Part D. In 2006, the average cost for State Plan Services for the ADvantage NF comparable population was $4,564 – about $650 more than total cost in 2007. All of this cost reduction was due to reduced drug costs. Since 2007 State Plan costs seem to have been driven by changes due to inflation and utilization. Consequently 2007 is being used as the base year from which to calculate average yearly increase in Factor G’.

Fiscal Year  
Clients Total Expenditures Average Cost  
2007 20,458 $65,361,653.60 $3,195  
2008 20,261 $64,233,492.85 $3,170  
2009 19,629 $64,650,942.82 $3,294  
2010 19,257 $61,366,831.71 $3,187  

The average percent change in NF average State Plan services costs from 2007 to 2010 is -0.3% per year. However, statistically there is no change in average cost form 2007 to 2010. Consequently, for 2012 (Renewal Year 1) and each subsequent waiver renewal year, the average cost for NF resident State Plan services cost (Factor G’) is estimated to be the average of the costs over the years 2007 through 2010 – $3,211.40.

**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.
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

<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Health Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2700803.96</td>
</tr>
<tr>
<td>Adult Day Health (ADH)</td>
<td>15 minutes</td>
<td>529</td>
<td>2539.00</td>
<td>1.99</td>
<td>2672830.69</td>
<td></td>
</tr>
<tr>
<td>Personal Care in ADH</td>
<td>1 Session</td>
<td>51</td>
<td>71.00</td>
<td>7.67</td>
<td>27773.07</td>
<td></td>
</tr>
<tr>
<td>Therapy in ADH</td>
<td>1 Session</td>
<td>4</td>
<td>5.00</td>
<td>10.01</td>
<td>200.20</td>
<td></td>
</tr>
<tr>
<td>Case Management Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>56253158.64</td>
</tr>
<tr>
<td>Case Management</td>
<td>15 minutes</td>
<td>21757</td>
<td>171.00</td>
<td>15.12</td>
<td>56253158.64</td>
<td></td>
</tr>
<tr>
<td>Personal Care Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>90149393.88</td>
</tr>
<tr>
<td>Personal Care</td>
<td>15 minutes</td>
<td>18954</td>
<td>1282.00</td>
<td>3.71</td>
<td>90149393.88</td>
<td></td>
</tr>
<tr>
<td><strong>GRAND TOTAL:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>203134131.41</strong></td>
</tr>
<tr>
<td>Total Estimated Unduplicated Participants:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>22021</td>
</tr>
<tr>
<td>Factor D (Divide total by number of participants):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>9224.56</strong></td>
</tr>
<tr>
<td>Average Length of Stay on the Waiver:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>289</strong></td>
</tr>
<tr>
<td>Waiver Service/ Component</td>
<td>Unit</td>
<td># Users</td>
<td>Avg. Units Per User</td>
<td>Avg. Cost/ Unit</td>
<td>Component Cost</td>
<td>Total Cost</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------</td>
<td>---------</td>
<td>---------------------</td>
<td>-----------------</td>
<td>----------------</td>
<td>------------</td>
</tr>
<tr>
<td>Respite Total:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>428691.96</td>
</tr>
<tr>
<td>In-Home Respite</td>
<td>15 minutes</td>
<td>187</td>
<td>405.00</td>
<td>3.71</td>
<td>280976.85</td>
<td></td>
</tr>
<tr>
<td>Extended In-Home Respite</td>
<td>1 Day</td>
<td>1</td>
<td>3.00</td>
<td>166.05</td>
<td></td>
<td>498.15</td>
</tr>
<tr>
<td>Nursing Facility Respite</td>
<td>1 Day</td>
<td>66</td>
<td>16.00</td>
<td>139.41</td>
<td></td>
<td>147216.96</td>
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<tr>
<td>Prescribed Drugs Total:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5906486.25</td>
</tr>
<tr>
<td>Prescribed Drugs</td>
<td>1 Drug</td>
<td>3105</td>
<td>25.00</td>
<td>76.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Total:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>15 minutes</td>
<td>0</td>
<td>0.00</td>
<td>13.90</td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>Advanced Supportive/Restorative Assistance Total:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2149472.85</td>
<td></td>
</tr>
<tr>
<td>Advanced Supportive/Restorative Assistance</td>
<td>15 minutes</td>
<td>661</td>
<td>815.00</td>
<td>3.99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisted Living Services Total:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2526795.00</td>
<td></td>
</tr>
<tr>
<td>Tier One</td>
<td>1 Day</td>
<td>150</td>
<td>270.00</td>
<td>62.39</td>
<td></td>
<td>2526795.00</td>
</tr>
<tr>
<td>Tier Two</td>
<td>1 Day</td>
<td>0</td>
<td>0.00</td>
<td>0.01</td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>Tier Three</td>
<td>1 Day</td>
<td>0</td>
<td>0.00</td>
<td>0.01</td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>Consumer-Directed Personal Assistance Supports and Services Total:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6041745.59</td>
<td></td>
</tr>
<tr>
<td>Personal Services Assistance (PSA)</td>
<td>15 minutes</td>
<td>650</td>
<td>2885.00</td>
<td>2.93</td>
<td></td>
<td>5494482.50</td>
</tr>
<tr>
<td>Advanced PSA</td>
<td>15 minutes</td>
<td>77</td>
<td>1452.00</td>
<td>3.47</td>
<td></td>
<td>387959.88</td>
</tr>
<tr>
<td>Goods &amp; Services</td>
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</table>

**GRAND TOTAL:** 203134131.41

Total Estimated Unduplicated Participants: 22021
Factor D (Divide total by number of participants): 9224.56
Average Length of Stay on the Waiver: 289
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: | | | | | | 2954313.04

GRAND TOTAL: 203134131.41
Total Estimated Unduplicated Participants: 22021
Factor D (Divide total by number of participants): 9224.56
Average Length of Stay on the Waiver: 289

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<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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<td>Nursing Facility Respite</td>
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**GRAND TOTAL:** 216339792.83

Total Estimated Unduplicated Participants: 22731

Factor D (Divide total by number of participants): 9517.39

Average Length of Stay on the Waiver: 288
<table>
<thead>
<tr>
<th>Waiver Service/Component</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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</table>

| Environmental Accessibility Modifications Total: |                      |                      |                     |                |                | 137986.20  |
| Environmental Accessibility Modifications | 1 project | 45      | 1.00                | 3066.36        |                |             |

| Home-Delivered Meals Total: |                      |                      |                     |                |                | 15010407.90 |
| Home-Delivered Meals | 1 Meal | 13389     | 222.00              | 5.05            |                |             |

| Hospice Care Total: |                      |                      |                     |                |                |             |
| Hospice Care | 1 Day | 136      | 114.00              | 127.98          |                |             |

| Institution Transition Services Total: |                      |                      |                     |                |                | 63395.00    |
| Institution Transition Services | 15 minutes | 409     | 10.00               | 15.50           |                |             |

| Nursing Total: |                      |                      |                     |                |                |             |
| Nursing | 15 minutes | 20662     | 16.00               | 15.14           |                |             |

| Personal Emergency Response Systems Total: |                      |                      |                     |                |                | 1634223.60  |
| Personal Emergency Response Systems | 1 month | 5865     | 9.00                | 30.96           |                |             |

| Specialized Medical Equipment and Supplies Total: |                      |                      |                     |                |                |             |
| Specialized Medical Equipment and Supplies | 1 item | 16321    | 756.00             | 1.21           |                |             |

| Therapy Services Total: |                      |                      |                     |                |                | 57994.46    |
| Physical Therapy | 15 minutes | 132     | 29.00              | 14.35           |                |             |
| Occupational Therapy | 15 minutes | 7      | 30.00               | 14.31           |                |             |
| Speech/ Language Therapy | 15 minutes | 1      | 4.00               | 14.39           |                |             |

**GRAND TOTAL:** 216339792.83

**Total Estimated Unduplicated Participants:** 22731

**Factor D (Divide total by number of participants):** 9517.39

**Average Length of Stay on the Waiver:** 288

---

**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**

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**GRAND TOTAL:** 226125130.19

- Total Estimated Unduplicated Participants: 23615
- Factor D (Divide total by number of participants): 9575.49

**Average Length of Stay on the Waiver:** 287
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<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
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<td></td>
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Total Estimated Unduplicated Participants: 23615

Factor D (Divide total by number of participants): 9575.49

Average Length of Stay on the Waiver: 287

https://wms-mmdl.cdsvdc.com/WMS/faces/protected/35/print/PrintSelector.jsp
### 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

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<tr>
<th>Waiver Service/Component</th>
<th>Unit</th>
<th># Users</th>
<th>Avg. Units Per User</th>
<th>Avg. Cost/Unit</th>
<th>Component Cost</th>
<th>Total Cost</th>
</tr>
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<tbody>
<tr>
<td>Adult Day Health Total:</td>
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<td></td>
<td></td>
<td></td>
</tr>
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<td>Adult Day Health (ADH)</td>
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<td>1.99</td>
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<td>71.00</td>
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<td>Case Management Total:</td>
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<td>65933794.50</td>
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<td>Case Management</td>
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<td>170.00</td>
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**GRAND TOTAL:** 241354729.74  
Total Estimated Unduplicated Participants: 24337  
Factor D (Divide total by number of participants): 9917.19  
Average Length of Stay on the Waiver: 288
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**GRAND TOTAL:** 241354729.74

Total Estimated Unduplicated Participants: 24337
Factor D (Divide total by number of participants): 9917.19

Average Length of Stay on the Waiver: 288
### 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

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<th>Avg. Cost/Unit</th>
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Total Estimated Unduplicated Participants:

Factor D (Divide total by number of participants):

Average Length of Stay on the Waiver:
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**GRAND TOTAL:** 25733248.68

**Total Estimated Unduplicated Participants:**

Factor D (Divide total by number of participants):

**Average Length of Stay on the Waiver:** 289
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