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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
The following are significant changes to the approved waiver that are being made in this renewal application:

- (1)Performance Measures for each assurance have been updated using guidance from HCB setting regulations and CMS Modifications to Quality Measures & Reporting Requirements in 1915 (c) HCBS Waivers, that includes performance measures related to restrictive interventions and an outcome-based performance measure addition;
- (2)Removal of Speech and Language services-this service has not been utilized therefore, we are asking the services be removed;
  (3)Removal of waiver to limit CD PASS-this service has not been provided statewide in the past and required a "waiver of statewideness" however, we have expanded CD PASS statewide and ask that the restriction be removed, as well as consideration for Independence Plus designation;
  (4) Update reporting categories with Critical Incident Reporting;
  (5) Adding language limiting conflict of interest for service plan development and monitoring with service delivery; and
  (6) Other changes include general clarification, alignment with state statute and clean-up.

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: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: OK.0256
Waiver Number:OK.0256.R05.00
Draft ID: OK.012.05.00

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

Regular Waiver

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

07/01/16

Approved Effective Date: 07/01/16

1. Request Information (2 of 3)

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

- [ ] **Hospital**

  Select applicable level of care

  - ( ) **Hospital as defined in 42 CFR §440.10**

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

  - ( ) **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

- [x] **Nursing Facility**

  Select applicable level of care

  - (•) **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

- (•) **Not applicable**
- ( ) **Applicable**

  Check the applicable authority or authorities:

  - [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
  - [ ] **Waiver(s) authorized under §1915(b) of the Act.**

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

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

    - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
    - [ ] **§1915(b)(2) (central broker)**

- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
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 and Occupational
• 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 objective of the program is to offer to every individual who requests, and is medically and financially eligible, the ability to choose between nursing facility and home and community based services, with free choice of available providers for the services included in the individual's plan of 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 statewide. The program is cost effective, in that Medicaid expenditures for services under the ADvantage Waiver 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 (DHS), 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, Aging Services of DHS 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 statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
On June 12, 2015, DHS Aging Services emailed all provider agencies a bulletin regarding the quarterly provider meeting on June 25, 2015.

On June 25, 2015, DHS Aging Services held the quarterly provider meeting, in Concourse Theatre in the DHS Sequoyah Building in OKC, reviewed upcoming Waiver application, and requested provider participants to be involved with provider workgroup to review the ADvantage waiver application for 2016-2021. No comments or questions received.

On August 10, 2015, DHS Aging Services sent out information to providers that request participation in provider work group, including an extended number of the providers, to schedule a meeting held August 18, 2015 with a diverse group of providers respective to services and urban/rural representation. Eleven providers were invited.

On August 18, 2015, DHS Aging Services Medicaid Services Unit (MSU) met in Tulsa at the Medicaid Services Unit ADvantage Administration office, with providers who agreed to participate in waiver workgroup. MSU presented waiver and step by step went through proposed updates with the provider workgroup. Seven providers attended. Provider workgroup provided several recommendations regarding the waiver and specific waiver policy to be addressed. Provider workgroup recommendation has been included in this application.

On September 18, 2015, DHS Aging Services emailed all provider agencies a bulletin regarding the quarterly provider meeting on September 28, 2015.

On September 28, 2015, DHS Aging Services held the quarterly provider meeting at Medicaid Services Unit ADvantage Administration office in Tulsa, OK. Thirty-three providers attended. A review of the ADvantage waiver application was given with recommendations from the provider work group. No comments or questions received.

On March 1, 2016 the OHCA SoonerCare Tribal Consultation Meeting included a presentation of the proposed renewal application.

The ADvantage renewal application was placed on the OHCA website for public comment from March 1 – March 30th.

http://www.okhca.org/individuals.aspx?id=16904
http://www.okhca.org/providers.aspx?id=12003
•

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

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

7. Contact Person(s)

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

Last Name:

Antwine

First Name:

Lekenya

Title:

Waiver Administration Coordinator

Agency:

Oklahoma Health Care Authority

Address:

4345 N. Lincoln Boulevard

Address 2:

City:

Oklahoma City

State: **Oklahoma**

Zip:

73105

Phone:

(405) 522-7552 **Ext:** **TTY**

Fax:

(405) 520-3408

E-mail:

Lekenya.Antwine@okhca.org

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

Last Name:

Barnett

First Name:

Pearl

Title:

Programs Administrator, Medicaid Services Unit

Agency:

Department of Human Services, Aging Services

Address:

823 South Detroit Avenue, 4th Floor

Address 2:

City:

Tulsa

State: **Oklahoma**

Zip:

74120

Phone:

(918) 933-4969 **Ext:** ☐ **TTY**

Fax:

(405) 230-8008

E-mail:

Pearl.Barnett@okdhs.org

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Nico Gomez

State Medicaid Director or Designee

Submission Date: Jul 26, 2016

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

Last Name: Pasternik-Ikard

First Name: Becky

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) 522-7208 **Ext:** ☐ **TTY**

Fax: (405) 530-3300

E-mail:
Becky.Pasternik-Ikard@okhca.org

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

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

Purpose

The Centers for Medicare and Medicaid Services (CMS) published its final rule related to Home and Community Based Services (HCBS) for Medicaid funded long-term services and supports provided in residential and non-residential home and community based settings. The final rule took effect March 17, 2014. States are required to submit transition plans to CMS within a year of the effective date indicating how they intend to comply with the new requirement within a reasonable time period. If states amend or renew any of their currently operating waivers or state plan amendments prior to the effective date, that action serves as a trigger for the state to submit a transition plan for all its waivers under 1915(c), as well as any state plan amendments under 1915(i) or 1915(k) within 120 days of the amendment/renewal submission. The following is Oklahoma's amended statewide transition plan pursuant to this requirement.

Background

This document describes the Statewide Transition Plan (SWTP) of the Oklahoma Health Care Authority (OHCA), the single State Medicaid Agency, as required by the CMS final regulation related to new federal requirements for home and community-based (HCBS) settings. This SWTP includes the state's assessment of its regulations, standards, policies, licensing

requirements, and other provider requirements to ensure settings comply with the new federal requirements. Additionally, the transition plan will describe action the state proposes to assure full and on-going compliance with the HCBS settings requirements.

Overview

Oklahoma administers/operates six 1915 (c) waivers. There are approximately 26,106 individuals served in the State of Oklahoma through one of these 1915 (c) waivers. Oklahoma does not currently offer services through the state plan under 1915 (i) or 1915 (k) authority. Oklahoma operates two waiver programs with a nursing facility level of care designation and four waiver programs with an ICF/ID level of care designation. Across the six waiver programs, there are eight distinct settings utilized among Home and Community Based Waiver members, that does not include the member's owned or family owned home. This document summarizes the State's preliminary assessment activities and its proposed strategy for continuous monitoring and remediation of HCBS settings for both the aged and physically disabled (NF-LOC) waivers and the developmental disabilities waivers (ICF/ID LOC). 3

Section A: NF LOC Waivers

Introduction

Oklahoma operates two 1915(c) waivers with a nursing facility (NF) level of care designation serving approximately 21,000 individuals per month in community settings. The State conducted a review of all of its applicable State statutes, administrative rules, approved waivers, provider requirements, and service specifications pertaining to the HCBS settings. The results of the State's systemic review are located in Appendix 1.

The following are the approved NF LOC Waiver Programs.
Medically Fragile – Serves individuals 19 years of age and older who meet hospital and/or skilled nursing level of care. The purpose of the waiver is to provide assistance for families who require long-term supports and services to maintain the medically fragile member in the family home while meeting their unique medical needs. Daily operation of this waiver is performed by the Oklahoma Health Care Authority.
ADvantage – Serves frail elderly individuals age 65 or older and adults age 21 and older with physical disabilities that would otherwise require placement in a nursing facility. Daily operation of this waiver is the responsibility of the Department of Human Services Aging Services (DHS-AS). The Oklahoma Health Care Authority retains administrative oversite of the waiver.

I. Assessment Methodology & Continued Monitoring

The Oklahoma Department of Human Services (DHS), Aging Services (AS), Medicaid Services Unit (MSU), Quality Assurance/Improvement (QAI) department, Provider Audit team conducts an annual on-site provider agency audit. Audits are completed using a representative sample of case records of Members receiving services in the Adult Day Health (ADH) and/or who reside in an Assisted Living facility (AL). Included in each audit is a survey of Member perception. Member Perception contacts are made with Members who were randomly selected for provider audit review in their ADH/AL setting, in the Member's home, or via telephone. Currently DHS-AS has been working with DHS, Developmental Disabilities Services (DDS), to complete Adult Day Site Visit Reports at the Adult Day Centers. DHS-AS Medicaid Services Unit is in the process of developing an Adult Day Health (ADH) and Assisted Living (AL) Consumer-Focused Quality Care Review (C-FQCR) tool during SFY16, to be used beginning SFY17. The C-FQCR tools are based on the provider agencies contractual documents, Oklahoma Administrative Code (OAC), Oklahoma statutes, and HCB Setting Final Rules. The tool is designed to measure provider compliance with defined standards and adherence to the waiver requirements, including Member choice of services and provider, training, compliance with delivery of services as authorized. The tool will also survey Member's perception of service delivery performance and support to integrate into the greater community. The Provider Audit team is responsible for monitoring and tracking provider's progress in complying with the performance measures and any necessary remediation. Each review includes a plan of correction that the agency completes, as well as a follow-up visit if there were any non-compliance issues with any of the requirements. 4
Population: All Members with service plans active during the reporting period
Sample Size/Methodology: Random cumulative sample selected according to the percentage of Members served by a single ADH/AL provider as a proportion of the total number of Members served receiving ADH/AL services on the Waiver. Sample size will be validated utilizing Raosoft Survey Design.

II. Assessment Process

The proposed action steps and timelines for the statewide transition plan are outlined in the grids found in Appendices 3 & 4. The proposed timelines are contingent upon CMS approval of the plan.

III. Remediation Strategy

a. Remediation
Any provider who scored below 100% on these HCBS settings compliance reviews will be required to complete a plan of correction developed by the review team, complete two progress reports over a 6-month period and a follow-up visit. The Plan of Correction includes the identification and cause of the problem, the proposed action/intervention, a monitoring plan, the person accountable, the implementation and projected completion dates and the expected outcome. The Progress Reports include the status of implementation, what data has been collected, the collection date and the person accountable. The Plan of Correction is submitted within 30 days from the date that the final reports are mailed to the agency and the Progress Reports are due every 30 days after the Plan of Correction is approved by the Programs Assistant Administrator of the Quality Assurance/Improvement department or designee. The Follow-up Audit is completed during the month following the final Progress Report and includes only those Conditions that required a Plan of Correction.
b. Improvement
Full compliance is requested for all HCB Setting requirements, as well as other performance measures to be reviewed during the audit. During this initial year of auditing, both the Quality Assurance and Improvement Advisor and the Quality Assurance and Improvement Programs Supervisor, will work with providers to come into full compliance on all HCB settings. Trainings have been conducted with providers to explain the monitoring method and answer any questions.

c. Plan for Relocation

1. Each Member has an individualized person-centered Service Plan, prepared by the ADvantage Case Manager in conjunction with the Interdisciplinary Team (IDT),completed during each Service Plan year or when living arrangements are modified. One section of the Service Plan is Life Transition Planning. In this area, contingency plans list choices by the Member if they can no longer stay at the assisted living and the parties available to assist with this transition. Also included is a goal addressing what will happen to the Member's belongings, should the Member have to move into an NF.

2. Each Member has an individualized person-centered Services Backup Plan crafted by the ADvantage Case Manager in conjunction with the IDT team completed during each Service Plan year or when living arrangements are modified. This Services Backup Plan includes contingency plans for direct care assistance, critical health and supportive services, equipment repair or replacement, medications, DME supplies, transportation, etc. First, second, and third tier designated backups are also listed on the plan. The plan is signed by the Member, ADvantage Case Manager and any witnesses, if applicable.

3. Should the setting fail to reach compliance, Members, ADvantage Case Managers and the IDT will strategize for all possible living options available in the community. Immediate coordination with the ADvantage Case Manager and all other IDT members requested by the Member are critical in determining the wishes of the Member and the options available to them in a somewhat limited timeframe.

Some of the options available would be as follows:

Assisted Living
•Transferring to another certified ADvantage Assisted Living Center
•Home with HCBS services and informal supports
•Home with Adult Day Health services
•Explore all assistance and living arrangements with family, friends
•Nursing facility placement (if necessary)

Adult Day Health
•Transferring to another Adult Day Health facility
•Remaining in the home with PCA services in place, in conjunction with informalsupports
•Move to a certified ADvantage Assisted Living Center
•Explore all assistance and living arrangements with family, friends.
•Nursing facility placement (if necessary)

IV. Baseline Assessment Process and Results

Baseline assessments were completed from August 2014 to March 2015. Providers received a survey via electronic mail and follow-up phone calls. The survey consisted of questions from the CMS Final Rule Exploratory Questions document. Follow-up calls were made to ensure that providers completed the survey in the allotted time frame. Surveys were sent to the entire NF LOC waiver setting locations. There was an 80% response rate on the survey. The State did reach out to those providers that did not respond to the survey. The State intends to assess these individuals in the next round of surveys through the annual provider audit process discussed in Section I, which includes a site visit. Assessment results indicate that 75% of settings assessed

comply with the HCBS Final Rule and 25% do not comply. For those settings that were found to be non-compliant, the State will take the steps listed above in the Remediation Section to ensure compliance by March 2019. We estimate based on the baseline assessments that at least 75% of all settings comply with the HCBS Final Rule and 25% are non-compliant. A more detailed overview of the survey and the survey results can be found in Appendix 3.

Section B: ICF/ID Waivers

Introduction

Oklahoma operates four home and community-based waivers which require an ICF/ID level of care. Average monthly enrollment in these waivers is approximately 5,382. In accordance with Title 340 Chapter 100 of the Oklahoma Administrative Code (OAC), the ICF/ID level of care is mutually exclusive from the nursing facility levels of care, which are necessary for enrollment in the waivers administered and operated by DHS DDS. The State conducted a review of all of its applicable State statutes, administrative rules, approved waivers, provider requirements, and service specifications. The results of the State's systemic review are located in Appendix 2.

The following are the approved ICF/ID Waiver Programs. Daily operation of each of these waivers is the function of the Oklahoma Department of Human Services – Developmental Disabilities Services.

Community – Serves individuals who are 3 years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an ICF/ID.

Homeward Bound – Serves individuals who are 18 years of age and older who have intellectual disabilities and certain persons with related conditions who (1) would otherwise require placement in an ICF/ID; and (2) have been certified by the U.S. District Court for the Northern District of Oklahoma as being members of the plaintiff class in Homeward Bound et al. v. The Hissom Memorial Center et al., Case No. 85-C-437-e.

In-Home Supports Waiver for Adults – Serves the needs of individuals 18 years of age and older with intellectual disabilities who would otherwise require placement in an ICF/ID.

In-Home Supports Wavier for Children – Serves the needs of children ages 3 through 17 years with intellectual disabilities who would otherwise require placement in an ICF/ID

I. Assessment Methodology & Continued Monitoring

An annual performance survey is conducted with agencies providing services through a Home and Community Based Waiver, to assess compliance with expectations defined in the agency's contract. A random sample is selected by DHS Office of Planning, Research and Statistics utilizing SPSS software. Surveys are conducted during each state fiscal year with providers of residential, vocational, or non-medical home supports. A representative sample of service 7
recipients from each of the four waivers is selected and then organized by provider agency who serves each service recipient included in the random sample. Notification is given to providers in the survey sample of when the survey will be completed. Surveys are completed through on-site visits.

II. Assessment Process

Developmental Disabilities Services (DDS) Quality Assurance staff review all applicable rules and provider contracts before the site visit. During the site visit, DDS Quality Assurance staff observes and conduct interviews with service recipients and staff involved in each type of service provided by the agency. Observations and interviews occur during various times of service delivery. Quality Assurance staff members evaluate information obtained from observations, interviews, and records reviewed in the context of appropriate and applicable contract standards, state, and federal rules. The survey tools utilized by the Quality Assurance team have been revised to specifically address requirements for home and community based settings. Once the site visit is complete, the DDS Quality Assurance team conducts an Exit conference with the provider agency, where the findings of the review are presented. The proposed action steps and timelines for the statewide transition plan are outlined in the grids found in Appendices 3 & 4. The proposed timelines are contingent upon CMS approval of the plan.

III. Remediation Strategy

Provider agencies surveyed by DD Quality Assurance Staff are given two weeks after the exit conference to send the Quality Assurance Staff a written response that identifies a date by which the agency will comply with cited requirements. The projected resolution date must be within two months of the exit conference. Any requests beyond two months of the date of the exit conference must be accompanied by a justification statement. Approval of extended resolution dates occurs only upon the presentation of evidence that extensive change in agency management systems or extensive expenditures is essential to the resolution of the issue. If a provider agency wishes to contest the findings of the performance review, the agency must submit a written appeal notice within two weeks of the exit conference. The written appeal notice does not relieve the agency from the responsibility to achieve resolution of contract deficiencies within two months from the date of the exit conference unless the appeal is approved. Provider agencies that receive citations will be re-surveyed to assess resolution of identified contract and rule deficiencies. DDS staff will continue to work with individual providers to identify and to achieve compliance within required time frames. Following the re-survey the provider is informed of the results. The provider may submit evidence contesting a citation. Any new citations found during the re-survey will be added to the report of the original survey. If the

agency fails to correct cited issues sanctions may occur, including potential relocation of members. This process will continue through June 2018. Beginning July 2018 all settings must be compliant with the HCBS settings regulations. All settings that are not fully compliant with the HCBS settings regulation will be identified and individuals receiving HCBS in 8 those settings will be relocated to a compliant setting. Oklahoma DDS staff will follow person centered planning in the transition process. Individuals will have choice among qualified providers, settings and be provided opportunities to visit several settings and given information to help them understand the various options available. Individuals will be relocated as necessary by March 15, 2019.

IV. Baseline Assessment Process & Results

First quarter provider surveys conducted during the period of July 2015 to September 2015 are being used for baseline information. This baseline assessment information was compiled utilizing the process outlined in the Assessment Methodology and Assessment Process Sections above. The baseline information included the portion of the annual representative sample served by the provider agencies surveyed, which comprised 207 service recipients and 213 different settings Assessment results indicate that 86% of settings assessed comply with the HCBS Final Rule and 14% do not comply. For those settings that were found to be non-compliant, the State will take the steps listed above in the Remediation Section to ensure compliance by March 2019. We estimate based on the baseline assessments that at least 85% of all settings comply with the HCBS Final Rule and 15% are non-compliant. Assessments are conducted to each provider on an annual basis, throughout the year, results are reported quarterly. A more detailed overview of the survey and the survey results can be found in Appendix 4.

Section C: Public Input

Oklahoma hosted meetings to include representatives from advocacy and stakeholder groups as well as the state agencies involved in operating its 1915(c) waivers. The purpose of the meetings was to plan the State's response to the new CMS rule on home and community based settings and to develop its approach to this statewide transition plan.

The Oklahoma Health Care Authority (OHCA) held a public meeting on March 10, 2015 to educate providers and stakeholders about the federal rules and the transition planning process, as well as to discuss preliminary survey results and answer questions. Final results of the surveys and transition plan was presented at the second public meeting on April 28, 2015.

OHCA held another public meeting on December 7, 2015 in an effort to make the public aware of the response letter from CMS concerning the Statewide Transition Plan, and the States process for making revisions and submitting the revised plan back to CMS. Stakeholders were made aware of the meeting through newspaper advertisements and the OHCA public website. The Public Meeting Notice was included in the 5 major Oklahoma Newspapers. The revised SWTP was posted to the OHCA website on December 15, 2015. There were no comments received.

The state assures that the settings transition plan included with this waiver amendment or renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan.

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 (DHS)

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 waiver requirements and as specified in the Interagency Agreement between OHCA and DHS. The operational and administrative functions specifically delegated, in whole or in part, to DHS through the Interagency Agreement are:
   • Member enrollment;
   • Assuring the 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 performance of DHS (Operating agency). The frequency of assessment of function depends upon the individual process but is usually on a monthly or quarterly basis. Described below are the different processes used to assess Operating agency performance.

Enrollment – The Medicaid Agency monitors the DHS 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 quarterly and includes senior level staff from the OHCA and DHS. This committee makes decisions related to eligibility and programs issues and provides direction for the Quality Management Strategies Council (QMSC). The QMSC, 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 senior level staff. The QMSC 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 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 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 the Quality Management Strategies Council (QMSC).

The performance is monitored by the OHCA Waiver Administration Director based on performance standards. DHS (the Operating agency) is responsible for providing upon request, 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. 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 DHS 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 electronic visit verification (EVV) system 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 (DHS)

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 DHS 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. DHS shares monitoring reports with the OHCA and the OHCA has input into meetings for which the contractor has a major responsibility. DHS and OHCA regularly review LTCA of Enid performance of contracted responsibilities during quarterly QMSC meetings in which the Director of LTCA of Enid participates.

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

   DHS and OHCA staff participate in monthly teleconference calls with EVV vendor staff to review issues related to

contracted responsibilities in implementing the EVV system, including issues raised by providers in using the system. DHS staff review on an ongoing basis EVV 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. DHS and OHCA regularly review EVV vendor performance of contracted responsibilities during quarterly QMSC meetings. Annually the DHS Contract Manager submits a summary Professional Services Evaluation report on EVV vendor performance to the DHS 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.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	✓	✓		
Waiver enrollment managed against approved limits	✓	✓		
Waiver expenditures managed against approved levels	✓	✓		
Level of care evaluation	✓	✓		
Review of Participant service plans	✓	✓		
Prior authorization of waiver services	✓	✓		
Utilization management	✓	✓	✓	
Qualified provider enrollment	✓	✓		✓
Execution of Medicaid provider agreements	✓			
Establishment of a statewide rate methodology	✓	✓		
Rules, policies, procedures and information development governing the waiver program	✓	✓		
Quality assurance and quality improvement activities	✓	✓		

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

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

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver

- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
Number and Percent of 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

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

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Data-Entry Retrieval System (ELDERS) and Waiver Information Management Systems (WMIS)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Except for Pharmacy and Medical Equipment and Supply providers, Number and percentage of providers certified as qualified by DHS prior to enrollment in accord with the DHS interagency agreement with the Medicaid Agency. Numerator: Number of providers certified as qualified by DHS prior to enrollment Denominator: Number of providers enrolled

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of 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:
ADvantage Waiver Management Information System (WMIS)

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Total number and percentage of members enrolled by DHS 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):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of member service plans that do not exceed approved waiver expenditure levels according to DHS 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:
ADvantage Waiver Management Information System (WMIS)

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

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of reports made accessible by EVV provider that are available for timely review, applicable, submitted as complete and in the correct format specified in the agreement with the State Numerator: Number of reports made available by EVV provider that are available for timely review, applicable, complete and in the correct format Denominator: Total Number of reports required

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of days EVV system operates and supports the required business applications for performance and 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
If 'Other' is selected, specify:
EVV Provider Performance monitoring

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percentage of initial LOC determinations made by DHS 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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Data-Entry and Retrieval System (ELDERS)

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of member 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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and 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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of provider 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
If 'Other' is selected, specify:
LTCA of Enid performance monitoring

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and 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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of Assisted Living (AL) and Adult Day Health (ADH) facilities that meet HCB settings requirements Numerator: Number of AL and ADH facilities with HCB setting evaluations completed and compliant Denominator: Total Number ADH and AL facilities

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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 DHS dedicated waiver staff are responsible for program monitoring and oversight and 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 DHS 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 Ethics of Care Committee (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, DHS is contacted directly for resolution and, if deemed necessary, DHS 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, DHS is contacted directly for resolution and, if deemed necessary, DHS 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, DHS is contacted directly for resolution and, if deemed necessary, DHS 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 DHS 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.

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

LTCA of Enid

The DHS 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. DHS shares monitoring reports with the OHCA and the OHCA has input into meetings of which the contractor is majorly responsible. 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 DHS 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)

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

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ **Aged or Disabled, or Both - General**					
	☑	**Aged**	65		☑
	☑	**Disabled (Physical)**	21	64	
	☑	**Disabled (Other)**	21	64	
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
		Technology Dependent			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐				☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

Disabled (Physical) and Disabled (Other) excludes individuals who have a developmental disability with a cognitive impairment related to their 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:

Once Members, who have disabilities, reach the age of 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:

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

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

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

- [ ] **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

- [ ] **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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 Medicaid Services Unit (MSU) 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.

All ADvantage applicants are given a Freedom of Choice form (ADv01) that outlines their right to a fair hearing by a DHS nurse at their time of UCAT III assessment. The member is informed by the DHS 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.

In accordance with 317:2-1-5. Hearing procedures, Wwhen 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)*:

- [x] **The participant is referred to another waiver that can accommodate the individual's needs.**
- [x] **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 cannot 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 reimbursement with State funded only. State-funded only plans must be reviewed and receive approval from the DHS Medicaid Services Director.

The member is informed in writing by DHS 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 DHS 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.

☑ **Other safeguard(s)**

Specify:

The member is informed by the DHS 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 B: Participant Access and Eligibility

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

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	21231
Year 2	22017
Year 3	22803
Year 4	23589
Year 5	24375

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

◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

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

e. **Allocation of Waiver Capacity.**

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

In accordance with ADvantage program medical eligibility determination[see OAC 317:35-17-5]; require nursing facility level of care [see OAC 317:35-17-2]; meet service eligibility criteria [see OAC 317:35-17-3(f)]; Eligibility and Countable Income [see OAC 317:35-5]; meet program eligibility criteria [see 317:35-17-3(g)] and complete all requirements of application for ADvantage services [see OAC 317:35-17-4]. Entry to the waiver is offered to individuals based on the date of their application for the waiver. The ADvantage waiver provides for the entrance of all eligible persons.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ○ **§1634 State**
   - ◉ **SSI Criteria State**
   - ○ **209(b) State**
2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ○ **No**
   - ◉ **Yes**

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

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

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☑ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

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

  Specify percentage: [ ]
- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- ☑ **A special income level equal to:**

Select one:

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

Specify percentage: [ ]

- ○ **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☐ **Medically needy without 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:

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

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

   i. **Minimum number of services.**

   The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

   - (●) **The provision of waiver services at least monthly**
   - ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

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

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

Specify the entity:

- ○ **Other**

Specify:

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 DHS 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.

According to OAC 317:35-17-2, Level of care medical eligibility determination, The DHS area nurse, or nurse designee, determines medical eligibility for ADvantage program services based on the DHS 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) Expanded criteria: 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 DHS nurse assesses the applicant in his/her home, or other appropriate setting, using the Uniform Comprehensive Assessment Tool (UCAT). The DHS 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 process, assesses the member in his/her home, or other appropriate setting, using the UCAT. The UCAT is then submitted to the DHS Medicaid Services Unit (MSU) as a part of the annual service plan reassessment packet, and reviewed by a DHS nurse for level of care re-evaluation determination. In the event the UCAT completed by the Case Manager does not provide sufficient documentation to support the member's continued eligibility for waiver services, the member is referred to the local DHS nurse who then assesses the member in his/her home, or other appropriate setting, using the UCAT. The DHS determines level of care based upon this assessment.

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):*

Member periodic reassessment is a component part of case management and is required annually as part of the annual service plan reevaluation process. Assessment occurs prior to the end of the service plan year, which coincides with the medical level of care (LOC) eligibility end date. The DHS Aging Services Medicaid Services Unit (MSU) 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 (DHS)

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
 # and percentage of applicants for whom there is a reasonable indication that services may be needed requesting services whose initial LOC evaluations were performed. Numerator: # of applicants with initial LOC evaluations performed Denominator: Total # of applicants requesting services for whom there is a reasonable indication that services may be needed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Data-Entry Retrieval System (ELDERS)

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Data-Entry Retrieval System (ELDERS) and Waiver Management Information System (WMIS)

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percentage of applicants receiving an assessment and LOC determination completed by qualified evaluators in accordance with state policy and procedure. Numerator: Number of applicants receiving an assessment and LOC determination completed by qualified evaluators in accordance with state policy and procedure Denominator: Total number of applicant LOC determinations

Data Source (Select one):
Other
If 'Other' is selected, specify:
Electronic Data-Entry Retrieval System (ELDERS)

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

DHS 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 LOC determination was not made by a qualified evaluator, the DHS 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 DHS NPAA will be required to submit, within five working days of request, a corrective action plan to the DHS MSU Programs Administrator or MSU Director.

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 Ethics of Care Committee (EOCC) for appropriate follow-up to safeguard the health and safety of members affected.

Quarterly, DHS will provide reports of remediation and corrective action plans (if any) to the Quality Management Strategies Council (QMSC) and to the OHCA Director of Waiver Administration and Development.

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

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

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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 DHS 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. During this discussion, the DHS nurse educates the member and family on CMS' conflict free case management requirements in order to support informed decision making.

If the member and/or family decline to make a provider choice, the nurse documents that decision on the member choice form (ADv-01). The DHS Medicaid Services Unit (MSU) uses a rotating system to select a case management agency and a home care 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, or the member's choice to decline making a selection of providers, and the agreement (by dated signature) of the member to receive services provided by the determined 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 DHS offices and stored on DHS Internal IT systems.

Appendix B: Participant Access and Eligibility

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

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

Service Type	Service		
Statutory Service	**Adult Day Health**		

Service Type	Service		
Statutory Service	Case Management		
Statutory Service	Personal Care		
Statutory Service	Respite		
Extended State Plan Service	Prescribed Drugs		
Extended State Plan Service	Skilled Nursing		
Other Service	Advanced Supportive/Restorative Assistance		
Other Service	Assisted Living Services		
Other Service	Consumer-Directed Personal Assistance Supports and Services		
Other Service	Environmental Accessibility Modifications		
Other Service	Home-Delivered Meals		
Other Service	Hospice Care		
Other Service	Institution Transition Services		
Other Service	Nursing		
Other Service	Personal Emergency Response Systems		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Therapy Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: 04 Day Services

Sub-Category 1: 04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**

- (●) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services furnished on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational, and speech therapies may be indicated on the individual's plan of care as enhancements to basic adult day care services.

Personal care service enhancement in Adult Day Health Care is assistance in bathing and/or hair care. Assistance with eating, mobility and toileting are personal care services that are integral to the Adult Day Health Care service and are covered by the Adult Day Health Care basic reimbursement rate. Assistance with bathing, hair care, or laundry is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing, hair washing or laundry service will be authorized when an ADvantage waiver member who uses Adult Day Health Care requires assistance with bathing, hair care, or laundry to maintain health and safety.

Physical and occupational therapies are defined under skilled therapy services.

Speech and Language Therapy Services

Service Definition: The skills of a speech-language pathologist are required for the assessment of a member's rehabilitation needs (including the causal factors and the severity of the speech and language disorders) and rehabilitation potential. Re-evaluation would only be considered reasonable and necessary if the member exhibited a change in functional speech or motivation, clearing of confusion, or the remission of some other medical condition that previously contraindicated speech-language pathology services. When a member is undergoing restorative speech-language pathology services, routine re-evaluations are considered to be a part of the therapy and could not be billed as a separate visit.

The services of a speech-language pathologist would be covered if they are needed as a result of an illness or injury and are directed toward specific speech/voice production.

Speech-language pathology would be covered when the services can only be provided by a speech-language pathologist and when it is reasonable to expect that the service will materially improve the member's ability to carry out independently any one or combination of communication activities of daily living in a manner that is measurable at a higher level 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 and cueing that directs a member toward speech-language communication goals in the plan of treatment would be a covered speech-language pathology service.

The services of a speech-language pathologist to train the member, family, or other caregivers to augment the speech-language communication, treatment, or to establish an effective maintenance program would be covered speech therapy.

The services of a speech-language pathologist to assist beneficiaries with aphasia in rehabilitation of speech and language skills are covered when needed by a member.

The services of a speech therapist to assist individuals with voice disorders to develop proper control of the vocal and respiratory systems for current voice production are covered when needed by a member.

Speech and Language Therapy Services shall be included in the individual service plan only when it is necessary to prevent or delay the permanent institutionalization of an individual.

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

Therapy services, when indicated in the recipient's plan of care, will be furnished as an enhancement to basic Adult Day Health Care services. As a cost-containment measure, enhanced personal care and/or therapies in Adult Day Health Care are reimbursable on a per unit 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 services are authorized in 15 minute units, with no more than 32 units (8 hours) authorized per day. Units of Adult Day Health service enhancement for Personal Care or for Physical, Occupational, or Speech Therapy are authorized and billed in addition to standard Adult Day Health service units. Adult Day Health Personal Care Enhancement is a maximum one unit per day for either bathing, hair care, or laundry service.

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 services to meet their needs in their home either before or after the period of service in Adult Day Health for that day, if necessary. If personal care services are needed in the home before or after the period of time when the person is being served in an Adult Day Health Center, the member's Case Manager incorporates these services into the member's service plan.

MSU 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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Therapist
Agency	Adult Day Care Center

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;

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 Title 63 O.S., Sec. 1-870, et seq.
Certificate *(specify):*
None
Other Standard *(specify):*
1) ADvantage Qualified Provider Certification [OAC 317:30-5-761]
2) Medicaid Provider Contract
Verification of Provider Qualifications
Entity Responsible for Verification:
Oklahoma Department of Human Services (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Case Management
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Case Management services are services that assist a member in gaining access to medical, social educational or other services, regardless of payment source of services that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments for service plan development. Case managers develop the member's comprehensive plan of care, listing services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers are responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support.
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:

Provider Category	Provider Type Title
Agency	Case Management Agency

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:
Case Management Agency
Provider Qualifications
License *(specify):*
None

Certificate *(specify):*
None
Other Standard *(specify):*
•1) ADvantage Qualified Provider Certification [OAC 317:30-5-761]
2) Medicaid Provider Contract
3) Minimum qualifications for Case Manager are:
a. RN with one year paid professional experience; or
b. LPN with one year paid professional experience; or
c. Baccalaureate degree and one year *paid professional experience with the aging or disabled population obtained before or after receipt of degree; and
4) A minimum of one week of orientation to the agency's policies and procedures to include shadowing a certified Case Manager in the field (documentation of orientation to be submitted to the MSU before the ADvantage CM Training date).

*Paid professional experience may include, but is not limited to: CNA, CMA, CHHA or PCA experience.

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 (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Assistance with eating, bathing, dressing, personal hygiene activities of daily living. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed-making, dusting and vacuuming, or other tasks or errands which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

Personal care services under the State Plan differ in service definition from the services offered under the waiver including provider training requirements and qualifications. Members served under the waiver have a higher level of care need than those individuals served under State Plan Personal Care. Waiver members have to meet nursing facility level of 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 planning is not required for State Plan Personal Care services. State Plan Personal Care is afforded to individuals with lower level of care needs than in this waiver.

Supervision of personal care providers will be furnished by a registered nurse, licensed to practice nursing in the State or by a licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law or by the participant-employer of the personal care provider. Frequency or intensity of supervision is a minimum of every 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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

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

Certificate *(specify):*
None
Other Standard *(specify):*
1) ADvantage Qualified Provider Certification [OAC 317:30-5-761]
2) Medicaid Provider Contract
3) 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., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, name does not appear on the OKDHS Community Services Workers Registry.
4) Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification.

Training Requirements:

1) Demonstrates competency to a qualified evaluator to meet the personal care assistance needs of the individual member.

Nurse Supervision Requirements:

1) Registered nurse (RN) supervision of Personal Care services is a state requirement of the Medicaid Program. Each Medicaid provider agency must have an RN available to perform specific supervisory functions unless the plan of care includes only homemaker chore tasks. If the plan contains homemaker chores only, the agency may designate the qualifications of the supervisor. While some of the nursing supervision functions may be delegated to a licensed practical nurse (LPN), as described below, the provider agency is still responsible for having registered nurse staff available to perform specified supervisory tasks.
2) At a minimum the provider agency must meet services quality monitoring and oversight requirements in accordance with OAC 310: 662-5-4. For supervisory monitoring visits, the RN shall visit the member at home or determine that an LPN make the visit based upon the types of Personal Care services authorized in the member's plan of care.
3) The RN has the responsibility of determining the status of the present plan of care in meeting the member's needs. The LPN is under the direct supervision of the RN. This supervision includes a review and co-signature by the RN for all reports prepared by the LPN and consultation between RN and LPN as needed.

Verification of Provider Qualifications

Entity Responsible for Verification:
Oklahoma Department of Human Services (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: 09 Caregiver Support

Sub-Category 1: 09012 respite, in-home

Category 2: 09 Caregiver Support

Sub-Category 2: 09011 respite, out-of-home

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following locations:
1) In-Home Respite in the individual's home or place of residence;
a. 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.
b. 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.
2) Nursing Facility Respite in a Medicaid certified Nursing Facility.
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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care
Agency	Nursing Facility

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):*
1) ADvantage Qualified Provider Certification [OAC 317:30-5-761]
2) Medicaid Provider Contract
3) 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., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, name does not appear on the DHS Community Services Workers Registry.
4) Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification.
Verification of Provider Qualifications
Entity Responsible for Verification:
Oklahoma Department of Human Services (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrollment

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

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):*
1) ADvantage Qualified Provider Certification [OAC 317:30-5-761]
2) Medicaid Provider Contract
Verification of Provider Qualifications
Entity Responsible for Verification:
Oklahoma Department of Human Services (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Prescribed Drugs

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11060 prescription drugs

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Prescribed drugs available through the approved State Plan will be provided, except that the limitations on amount, duration and scope will be as specified below rather than as specified in the State Plan. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver 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 not be provided under the provisions of this Waiver, to Waiver recipients who are dual (Medicare/Medicaid) eligible. Extended state plan prescribed drugs provided, under the provisions of this Waiver, will be limited to seven (7) prescribed drugs per recipient per month. For waiver recipients who may require more than thirteen (13) prescriptions per month ("brand name" and generic products combined) or who may require more than three (3) "brand name" products per month, a written request may be made on their behalf to have their additional prescription needs reviewed. In addition to making a determination of "medical necessity" for the additional prescription product(s) being requested, this review could result in a recommendation that certain medication regimens be altered or discontinued. Recipient co-payments will be required for each monthly prescribed drug. Co-payment amounts will be the same as required for SoonerCare State Plan 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:

Provider Category	Provider Type Title
Agency	Pharmacy

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Pharmacy
Provider Qualifications
License *(specify):*
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 (OHCA)
Frequency of Verification:
Prior to enrollment and annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Skilled Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Skilled Nursing: Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are ordered by a licensed medical physician, osteopathic physician, physician assistant or advanced practice nurse and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

Skilled Nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are for treatment of a disease or a medical condition and are beyond the scope of ADvantage Nursing Services. ADvantage Skilled Nursing services are provided when 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 duplication of payment for skilled nurse services.

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

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 pertaining to the care of the member. If the member has an ongoing need for service activities, which require more or less units than authorized, the RN shall recommend, in writing, that the Plan of Care be revised.

The Oklahoma MMIS forces payment of Medicare, then State Plan Medicaid and then ADvantage to prevent duplication of payment for skilled nursing services.

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:

Provider Category	Provider Type Title
Agency	Skilled Nursing

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 567.16

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 (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Advanced Supportive/Restorative Assistance

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Advanced 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 devices and procedures related to altered body function.

Advanced Supportive/Restorative Care is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Supportive/Restorative Care services should be referred to their attending physician who may, if appropriate, order home health 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 with well-healed stoma) and external, in dwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;
• Remove external catheters, inspect skin and reapplication of same;
• Administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (pre-packaged only) with members without contraindicating rectal or intestinal conditions;
• 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 (opening of compartments, handing container to Member. ASR assistant may not handle actual medications);

• 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 practical nurse; and
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.

MSU /SPA in reviewing service plan requests for Advanced Supportive/Restorative Assistance will not give approval if Personal Care or State Plan Home Health benefits could be used instead. In addition, the SPA Clinical Review team will ensure that duplicative services are not authorized.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care

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]
2) Medicaid Provider Contract
3) 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 notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, name does not appear on the OKDHS Community Services Workers Registry.
4) Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification.

Training Requirements: All Advanced Supportive/Restorative Assistance aides are required to receive the same basic Personal Care training as a Personal Care aide, and also must be given the following training prior to delivery of Advanced Supportive/ Restorative Assistance services:

The Provider must provide to its staff Advanced Supportive/Restorative Assistance training specific to the care needs of member requiring Advanced Supportive/Restorative Assistance. The provider shall have written plans of the training; such training must include at a minimum the following topics:

• 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 by the Personal Care aide in the aide's personnel file.

Prior to performing any Advanced Supportive/Restorative Assistance task for any member for the first time, the aide must demonstrate competency in the tasks on the member's plan of care in an on-the-job training session conducted by the registered nurse, or an LPN working under the direction of a registered nurse. The nurse must document the aide's competency in performing each task in the aide's personnel file. The RN/LPN visit required in order to conduct such training and testing is a billable visit.

The required demonstration of each Advanced Personal Care task during an on-the-job training session with a RN or LPN may not be waived. Advanced Supportive/Restorative Assistance aides must also receive annual in-service training.

The Advanced Supportive/Restorative Assistance provider shall have written documentation of all basic

and in-service training provided which includes, at a minimum, a report of each employee's training in that employee's personnel record. The report shall document the dates of all classroom or on-the-job training, trainer's name, topics, number of hours, and location; the date of first unsupervised service delivery; and shall contain the worker's signature. If a provider waives the in-service training, the employee's training record shall contain supportive data for the waiver of training.

Nurse Supervision Requirements:

Registered nurse supervision is essential to the safe provision of Advanced Supportive/Restorative Care services. Certain nurse functions for Advanced Supportive/Restorative Care members may be performed by a licensed practical nurse; others must be performed by a registered nurse. The following outlines the nursing requirements for Advanced Supportive/Restorative Care members:

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 evaluation of the adequacy of the authorized services to meet the needs and conditions of the member, and shall assess the Advanced Supportive/Restorative Care Aides' ability to carry out the authorized services.

• 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 within 48 hours of each evaluation.

Conduct annual assessment/reassessment visits and develop the plan of care for all subsequent years for members with Advanced Supportive/Restorative Care needs, in collaboration with 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, and certify the successful completion of the task in the aide's personnel record. This visit may be authorized and reimbursed.

The licensed practical nurse may:

• Conduct the periodic authorized nurse visits to evaluate the condition of the Advanced Supportive/Restorative Care member. The visit reports must be forwarded to the RN supervisor for co-signatures.

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Department of Human Services (DHS)

Frequency of Verification:

Prior to Enrollment and Annually after Enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Assisted Living Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02033 in-home round-the-clock services, other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Assisted Living Services: Personal care and supportive services that are furnished to waiver members who reside in a homelike, non-institutional setting including 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming and medication assistance (to the extent permitted under State law).

Services that are provided by third parties must be coordinated with the Assisted Living Center (ALC) provider. Nursing services are incidental rather than integral to the provision of Assisted Living Services. ADvantage reimbursement for Assisted Living services includes the following: personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities and exercise and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities and exercise, are to meet specific needs of the participant as determined through individualized assessment and documented on the participant's service plan. Payment is not made for 24-hour skilled care. Federal financial participation (FFP) is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. The methodology by which the costs of room and board are excluded from payments for Assisted Living Services is described in Appendix I-5.
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.

MSU 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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living

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):*
Assisted Living Center 63 O.S. Sec 1-890.1, et seq.
Certificate *(specify):*
None
Other Standard *(specify):*
1) ADvantage Qualified Provider Certification [OAC 317:30-5-761; see Appendix C-2: 3-10 for standards in addition to licensure]
2) In addition, ADvantage certification requires ALC to meet the following Quality Assurance/ Quality Improvement standard:
3) The ALC shall have a written quality improvement plan that addresses the following:
4) Organizational structure, which includes, but is not limited to the existence of an organization chart and job descriptions;
5) Written Policies and Procedures which provide for a member complaint and grievance process, a member satisfaction evaluation process, employee education and training, and a process for assuring that members are “staffed” and receive the services they have been authorized to receive;
6) A Quality Assurance System which provides for self-audits, member satisfaction evaluation, and corrective action; and
7) Management Reports; and
8) Medicaid Provider Contract
Verification of Provider Qualifications
Entity Responsible for Verification:
Oklahoma Department of Human Services (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after Enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Consumer-Directed Personal Assistance Supports and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Consumer-Directed Personal Assistance Services and Support (CD-PASS): CD -PASS consists of Personal Services Assistance and Advanced Personal Services Assistance, optional expense account for goods and services, and administrative financial management services that enable an individual in need of assistance to reside in their home and in 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.

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:

o Bathing and personal hygiene;
o Dressing and grooming;
o Eating including meal preparation and cleanup; and

• Assistance with Homemaker-type tasks that may include shopping, laundry, cleaning and seasonal chores; and,
• Companion type service assistance that may include letter writing, reading, mail and providing escort or transportation to participate in approved activities or events;
o "Approved activities or events" means community civic participation guaranteed to all citizens such as the exercise of religion, voting or participation in daily life activities in which exercise of choice and decision-making is important to the member. These activities may include shopping for food, clothing or other necessities, or for participation in other activities or events that are specifically approved on the service plan;

The Personal Services Assistant hired by the member is responsible for delivery of Personal Services Assistance required by the member and authorized on the service plan.

Personal Care provider managed service delivery differs from Personal Services Assistance services provided under CD-PASS service option in provider type/mode of service delivery, definition and scope of services.

Provider type/mode of service delivery:

o 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
o Personal Services Assistance services are provided by a worker (PSA) employed by the member receiving services following a plan developed and supervised by the member

Service definition

o There is overlap in service definition in that both services are to meet ADL and/or IADL needs of the member. However, PCA services are only permitted for assistance in the home (or with prior approval) in a work/educational setting. PSA services are permitted in additional settings for events or activities to meet goals of service plan and with authorization through the service planning process

Scope of services

o PSA services may include companion type service assistance that may include letter writing, reading, mail and providing escort or transportation to participate in approved activities or events; whereas, these type of services are not within the scope of the provider managed ADvantage PCA services.

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 requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were 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 therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their attending physician, who may, if appropriate, order home health services.

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 well-healed stoma) and external, in dwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;

• Remove external catheters, inspect skin and reapplication of same;
• Administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (pre-packaged only) with members without contraindicating rectal or intestinal conditions;
• 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 with the plan of care, unless contraindicated by underlying joint pathology;
• Apply non-sterile dressings to superficial skin breaks 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 conducted with the member. The member must document the attendant's competency in performing each task in the APSA's personnel file. When deemed necessary by any member of the IDT, ADvantage Nursing services are authorized to provide assistance with training of the APSA and/or to provide nursing oversight monitoring for the delivery of APSA services. If required by any member of the IDT, a nurse is required to observe the successful execution by the APSA of each Advanced Personal Services Assistance task during an on-the -job training session, and certify the successful completion of the task in the APSA's personnel record. This visit may be authorized and reimbursed.

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 plan.

Goods and Services

Incidental goods and/or services necessary to support the Member/Employer in carrying out Employer responsibilities or for delivery of authorized CD-PASS services may be purchased if prior authorized through the CD-PASS budget and service plan processes. Each purchase of goods or services receives and administrative review of the supporting 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-PASS PSA and/or APSA services. All purchases of incidental goods and services are through the Financial Management Services provider. Invoices and other documentation of purchases of 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:

Provider Category	Provider Type Title
Individual	Personal Services Assistant
Individual	Advanced Personal Services Assistant

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., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, name does not appear on the OKDHS Community Services Workers Registry, DHS Child Care Restricted Registry, Oklahoma Sex Offender and Violent Offender Registries.
• Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification.

Training Requirements: Training provided by employer/participant to the personal services assistant, regarding specific tasks to perform. Demonstrates competence to perform required tasks to employer/participant satisfaction.
Verification of Provider Qualifications
Entity Responsible for Verification:

Employer/Participant

For criminal and abuse registry background checks, Employer/Participant jointly with the Oklahoma Department of Human Services
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 not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, name does not appear on the OKDHS Community Services Workers Registry, DHS Child Care Restricted Registry, Oklahoma Sex Offender and Violent Offender Registries.
• Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification.
• 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 must demonstrate competency in the tasks in an on-the-job training session conducted with the member. The member must document the attendant's competency in the APSA's personnel file. When deemed necessary by any member of the IDT, ADvantage Nursing services are authorized to provide assistance with training of the APSA and/or to provide nursing oversight monitoring for the delivery of APSA services. If required by any member of the IDT, a nurse is required to observe the successful execution by the APSA of each Advanced Personal Services Assistance task during an on-the-job training session, and certify the successful completion of the task in the APSA's personnel record.
Verification of Provider Qualifications
Entity Responsible for Verification:
Employer/Participant

For criminal and abuse registry background checks, Employer/Participant jointly with the Oklahoma Department of Human Services
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 Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit.

All services shall be provided in accordance with applicable State or local building codes and conforms to ADA Accessibility Guidelines – 28 CFR Part 36 Appendix A.

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 are 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:

Provider Category	Provider Type Title
Individual	Architects
Individual	Electrician
Individual	Mechanical Contractors
Individual	Engineers
Individual	Re-modelers and Builders
Individual	Plumbers

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:
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 (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrolled

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 (DHS)

Frequency of Verification:
Prior to Enrollment and Annually after enrolled

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 (DHS)

Frequency of Verification:
Prior to Enrollment and Annually after enrolled

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
• ADA Accessibility Guidelines –
28 CFR Part 36 Appendix A.

Verification of Provider Qualifications

Entity Responsible for Verification:
Oklahoma Department of Human Services (DHS)

Frequency of Verification:
Prior to Enrollment and Annually after enrolled

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 (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrolled

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 (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home-Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home-delivered Meal services provide meals, each with a nutritional content equal to one-third of the Dietary Reference Intake delivered to the home for members who are, unable to prepare meals, and who lack an informal provider to do meal preparation. Provision of Home-delivered Meals reduces the need for reliance on paid staff during some mealtimes 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 institutionalization of an individual.

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 a nursing facility.
(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 most cost-effective method of ensuring a nutritionally adequate meal.
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 the maximum number of meals per day allowed.

Safeguards:

If a member needs assistance with meals beyond the service limits for ADvantage home delivered meals, the member's Case Manager amends the service plan, based on member preference and service availability, to obtain assistance in preparing meals from informal supports, and/or to include non-waiver community- based home-delivered meals, and/or for the member to obtain meals from an Older American Act congregate meal site and/or arranges for ADvantage Personal Care services to assist in preparation of meals for the member in their home. In addition, the Case Manager assists the member to access food by referring the member for the Supplemental Nutrition Assistance Program (SNAP), assisting the member to access a community Food Pantry or any other local resources.

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:

Provider Category	Provider Type Title
Agency	Home-Delivered Meals

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 inspected and approved.
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 distribution of food.
Verification of Provider Qualifications
Entity Responsible for Verification:

Oklahoma Department of Human Services (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Hospice Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Hospice Care: Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six (6) months or less to live and orders Hospice Care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical and occupational therapy, medical social services, dietary counseling 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 manager

before hospice services are provided. The hospice plan of care is a separate document from the ADvantage Service Plan. However, the hospice plan of care and ADvantage Service Plan are coordinated to complement each other like a hand and a glove. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. A Hospice Plan of Care including certification / recertification of terminal illness signed by the physician must be provided for authorization of ADvantage Hospice services. Authorization of ADvantage Hospice services will correspond directly to the certification dates provided on the Hospice Plan of Care. Without duplicating waiver services, hospice services may include nursing and personal care, social worker services, grief and loss counseling for the member and 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 ADvantage Hospice services.

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 a maximum of six months. The total annual service plan authorization may not exceed 85% of the preceding year's Medicare annual cap payment amount.

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:

Provider Category	Provider Type Title
Agency	Hospice Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Hospice Care

Provider Category:
Agency

Provider Type:
Hospice Agency

Provider Qualifications

License *(specify):*
63 O.S. 1991, Sec. 1-860 et seq.

Certificate *(specify):*
Medicare Hospice certification

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 (DHS)

Frequency of Verification:
Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Institution Transition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Institution Transition Services: Institution Transition Services are those services that are necessary to enable an individual to leave the institution and receive ADvantage waiver services in their home and/or in the community.

Institution Transition Services may include:

• Case Management

Institution Transition Case Management services include member assessment, transition/move planning, monitoring of member status/readiness for transition, post-transition service planning, and/or arrangement/coordination of items or services provided by community resources for member transition from the institution to a community home setting. Reimbursement for items or services, other than case management, required for transition or establishment of community home setting are excluded from coverage under this definition of Institution Transition Services. Reimbursement for Institution Transition Case Management services is only made if the individual returns from the institution to their 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 from the institution.

Case Management Services:

Institution Transition Case Management Services are services required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization. ADvantage Transition Case Management Services assist institutionalized members that are eligible to receive ADvantage services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transition Case Management Services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the service plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution. Transition Case Management Services may be authorized to assist member's that have not previously received ADvantage services but have been referred by the MSU to the Case Management Provider for assistance in transitioning from the Institution to the community with ADvantage services support.

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:

Provider Category	Provider Type Title
Agency	Case Management

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Institution Transition Services

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 before or after receipt of degree; and,

[*Paid professional experience may include, but is not limited to: CNA, CMA, CHHA or PCA experience.]
A minimum of one week of orientation to the agencies policies and procedures to include shadowing a certified Case Manager in the field. (Documentation of orientation to be submitted to the MSU before the ADvantage CM Training date)

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 (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Nursing

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse,

licensed to practice in the State. The ADvantage Nursing Service consists of Nurse Assessment and Supervision and Private Duty Nursing. Private Duty Nursing is individual and continuous care provided to a participant at home by licensed nurses. 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 with stable, chronic conditions. These services are not intended as treatment for an acute health condition and may not include services, which would be reimbursable as skilled nursing care under either Medicare, Medicaid Home Health Programs or ADvantage Skilled Nursing. Should the nurse detect a need for services that would meet the definition of reimbursable skilled nursing care he/she must alert the member's physician and the ADvantage Program Administration.

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 supervision to the Personal Care Assistant and/or Advanced Supportive/Restorative aide and ongoing assessment of the suitability of the care plan to meet the member's needs. This is accomplished through the Interdisciplinary Team (IDT) planning process which includes the member, Case Manager, and other members of the IDT as appropriate. It is the responsibility of the RN to attend IDT Meetings required to develop or amend the Plan of Care.

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 and each 6 month monitoring visit and annual reassessment supporting the plan of care for personal care services provided by an in-home care provider and must be performed by the entity that provides or contracts with personal care workers to provide the personal care services. To promote continuity of care and timely service delivery, the ADvantage Program regards an agreement by a provider to produce a nurse evaluation as an agreement, as well, to provide those Medicaid in-home care services identified by the assessment/reassessment 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 Medicaid in-home care services identified by the assessment when the provider is certified and contracted to provide those 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 by the ADvantage Program DHS Medicaid Services Unit:

• Filling insulin syringes for a visually impaired diabetic who can self-inject the medication but cannot fill his own syringe. This service would include monitoring the member 's continued ability to self-administer the insulin;

• Setting up oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to disorientation/confusion, visual deficit, limited mobility or other limitations;
• Monitoring a member's skin condition when a member is at risk of skin breakdown due to immobility or incontinence or the member has a chronic impairment of the skin integrity requiring maintenance care and assessment;

• 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 to evaluate the condition of the member. A visit report will be made to the ADvantage Program case manager, to report the member's condition or other significant information concerning each Advanced Supportive/Restorative Care member; and
• Provide on-the-job training and competency testing for Advanced Supportive/Restorative Assistants.
• Provide to the case manager a copy of each Nursing Evaluation (within 24 hours) or monitoring visit (within 48 hours) paid for by the ADvantage Program.

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 care of the member. If the member has an ongoing need for service activities, which require more or less units than authorized, the RN shall recommend, in writing, that the Plan of Care be revised.
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.

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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care

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 567.16

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 (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Other Service

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

Service Title:

Personal Emergency Response Systems

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who have a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted. In addition, the member must demonstrate capability to comprehend the purpose of the PERS and ability to activate the PERS, have a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home and have a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying 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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical & Rehabilitative Equipment Manufacturers and Suppliers

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 (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Specialized medical 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 living, or to perceive, control, or communicate with the environment in which they live. Also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan.

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid State plan and shall exclude those items which are not of direct medical or remedial benefit to the member. This service is to secure medical equipment and supplies necessary for the welfare of the member, but shall exclude any equipment and/or supply items which are not of direct medical or remedial benefit to the waiver member. The service is authorized by the member's ADvantage Service Plan for equipment and supply items not available to the member under Medicare or the Medicaid State Plan and is necessary to prevent institutionalization. All items shall meet 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:

Provider Category	Provider Type Title
Agency	Home Care
Agency	Medical & Rehabilitative Equipment Manufacturers and Suppliers

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 (DHS)

Frequency of Verification:
Prior to Enrollment and Annually after enrolled

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 (OHCA)

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 Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

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

Service Title:
Therapy Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy

Category 2: 11 Other Health and Therapeutic Services

Sub-Category 2: 11090 physical therapy

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
SKILLED THERAPY 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 orders constitute skilled therapy services when, because of the member's condition, those activities require the involvement of a skilled therapist to meet the member's needs, promote recovery, and ensure medical safety. When the skills of a 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 covered, even if the skills of a therapist are not needed to carry out the activities performed as part of the maintenance program.

Skilled management involves a finding that the member's recovery and/or safety cannot be assured unless the total care, skilled or not, is planned and managed by skilled rehabilitation personnel. Documentation of the precautions needed as well as the medical complications and safety factors present which warrant skilled management is necessary.

The skills of a therapist are needed to establish a reasonable and necessary maintenance program until it can be safely and effectively carried out by nonskilled individuals. If a danger to the member's safety warrants the skills of a therapist to management and reevaluate periodically the appropriateness of the maintenance furnished, the services may be 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 the context of the member's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury:

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 amount, frequency, and duration of the services must be reasonable;

b. The services must be considered, under accepted standards of medical practice, to be specific and effective treatment for the member's condition; and

c. The services must be provided with the expectation, based on the assessment made by the physician, or if related to physical therapy made by the physical therapist, of the member's rehabilitation potential, that:

• 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 services to establish a maintenance program. A special medical complication might also necessitate skilled services to perform exercises or treatments that are normally considered nonskilled, even when no rehabilitation potential is

present.

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 precautions are covered to the extent that they are reasonable and necessary to treat the illness or injury. However, visits made by skilled therapists to the member's home solely to train other home health 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 properly trained to perform any services it furnishes. The cost of a skilled therapist's visit for the purpose of training home health agency staff is an administrative cost to the home health agency.
The following Skilled Therapy Services are covered:
• Physical Therapy;
• Occupational Therapy;

Physical Therapy Services

Service Definition: Physical Therapy services are those that prevent physical disability through the evaluation and rehabilitation of individuals disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as: massage, manipulation, therapeutic exercise, cold heat, hydrotherapy, electrical stimulation and light. Under the Physical Therapy Act, a physical therapist may evaluate a member’s rehabilitation potential and develop and implement an appropriate written therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed thirty (30) days. Any treatment required after the thirty day period shall require a physician’s prescription.. The therapeutic regimen may utilize a paraprofessional physical therapy assistant services within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the recipient's rehabilitative progress and will report to 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 institutionalization of an individual.

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 goals (to be approved by the physician), to manufacture or adapt the needed equipment to the member's use, to teach compensatory techniques, to strengthen the member as necessary to permit use of compensatory techniques, and to provide activities which are directed toward meeting the goals governing increased perceptual and cognitive function. Occupational therapy services would be covered at a duration and intensity appropriate to the severity of the impairment and the member's response to treatment.

A member's recovery and safety can be affected by perceptual and cognitive deficits. Deficits which impact the functional ADL, mobility, and/or safety of the member and necessitate skilled intervention must be documented.

The planning, implementing, and supervision of therapeutic programs, including but not limited to those listed below, are occupational therapy services if reasonable and necessary to the treatment of the member's illness or injury.

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 lost due to illness or injury. When vocational or prevocational assessment and training are related solely to specific employment opportunities, work skills or work settings such services would not be covered because they 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 the permanent institutionalization of an individual.

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

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:

Provider Category	Provider Type Title
Individual	Occupational Therapist
Agency	Home Care
Individual	Physical Therapist

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 (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrolled

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 (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrolled

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 (DHS)
Frequency of Verification:
Prior to Enrollment and Annually after enrolled

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:

Twenty-one not-for-profit organizations provide case management. Of these, five are Area Agencies on Aging (AAAs) [three are Councils of Government AAAs and two are Area Agencies on Aging only]; two are Adult Day Health Centers; one non-profit primarily provides services for the elderly; three are social service organizations that serve persons with disabilities, two also provide home care services; 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, forty-three other agencies are for-profit organizations. Of these, thirty-three provide home care services.

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 State Department of Health of Home Care Agencies and Adult Day Care Centers.

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:*

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

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

Facility Type	
Nursing Facility	

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:

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

Facility Capacity Limit:

N/A

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

Scope of State Facility Standards

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

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

Appendix C: Participant Services

C-2: 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:
1) Either no other provider is available; or,
2) Available providers are unable to provide necessary care to the member, or
3) 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:

1) meet the definition of a service/support as outlined in the federally approved waiver document;
2) be necessary to avoid institutionalization;
3) be a service/support that is specified in the individual service plan;
4) be provided by a spouse or guardian who meets the provider qualifications and training standards specified in the waiver for that service;
5) 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;
6) 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:
1) Spouse or guardian has resigned from full-time/part-time employment to provide care for the member, or
2) Spouse or guardian has reduced employment from full-time to part-time to provide care for the member, or
3) Spouse or guardian has taken a leave of absence without pay to provide care for the member, or
4) 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 MSU.

The spouse or guardian who is a service provider must comply with the following:

1) continue non-reimbursed family responsibilities of primary caregiver and emergency backup caregiver;
2) not provide more than 40 hours of reimbursed services in a seven day period;
3) 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;
4) maintain and submit time sheets and other required documentation for hours paid; and
5) the spouse or guardian as the member's care provider must be documented in the service plan.

Monitoring Requirements:

In addition to the standard Case Management monitoring and reporting activities required for all waiver services, the state obligates Case Management to the following additional monitoring requirements when a member elects to use a legally responsible spouse or guardian as a paid service provider:

1) at least quarterly reviews with the DHS MSU of expenditures, and the health, safety, and welfare status of the individual recipient;
2) Case Management face-to-face visits with the recipient on at least a monthly basis; monthly reviews by the Case Management provider 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 MSU.

  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. Monitoring requirements: In addition to the standard Case Management monitoring and reporting activities required for all waiver services, the state obligates Case Management to the following additional monitoring requirement when a member elects to use an existing informal support as a paid service provider: (1) Case Management face-to-face visits with the recipient on at least a monthly basis.

- ○ **Other policy.**

  Specify:

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

Throughout the year, any willing provider requesting to become an ADvantage provider submits their contact information to the MSU 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 MSU 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.

The MSU Contracts Department requests and reviews (as applicable, per type of provider) articles of incorporation, current organizational chart, proof of employee bonding, proof of liability insurance, all applicable licensures and certificates, agency brochures, verification of Medicaid contract from OHCA, signed Conditions of Provider Participation, Member Assurances, Service Standards, and HIPAA compliance forms. The MSU Contracts Department also ensures that providers have completed and signed the appropriate contract for each service they provide, as required by OHCA and DHS. New Provider Orientation required for Home Care, Case Management, Assisted Living, Hospice, Adult Day Health, and Meals.

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 Percentage of providers that continue to timely meet all 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 timely meet all 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:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percent of providers that initially timely met all licensing standards and requirements prior to furnishing waiver services. Numerator: Number of new licensed/certified Providers that timely met all 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:

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

Data Aggregation and Analysis:

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

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

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 timely met all waiver qualifications prior to providing services. Numerator: Number of non-licensed /non-certified Providers (by Type) that timely met all 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:

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

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Number and Percentage of Case Managers that timely met all training requirements as specified in the waiver. Numerator: Number of Case Managers that timely met all 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:

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
OHCA and DHS 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 DHS Point of Contact to resolve any problems in a timely manner. Problems requiring system change or additional staff will be addressed through the 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.

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.

DHS 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 DHS MSU Programs Assistant Administrator for Provider/ Member Relations contacts directly for resolution the Provider and appropriate DHS staff and, if deemed necessary, the Programs Assistant Administrator for Provider/Member Relations will be required to submit, within five working days of request, a corrective action plan to the Programs Administrator of the Medicaid Services Unit (MSU).

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

ii. **Remediation Data Aggregation**

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

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

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

☐ **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.

Please Refer to Main, Attachment#2

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
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:*

Case Management providers may not provide other program services such as personal care , nursing, and/or specialized medical equipment and supplies, unless provider availability limits the member's access to a willing and qualified provider. In the event there are no more than two Case Management provider agencies on referral in a county having only the same two providers for home care services, the member may select either agency, regardless of whether or not the Case Management provider has an interest in the selected home care provider agency.

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 DHS Medicaid Services Unit (MSU) prior to approval with regard to both the plan services and corresponding service units appearing to be appropriate to meet the member's assessed needs.

In the event the Member lives in an area in which no other alternative provider is available to provide services in the county of residence, the Case Manager will document the issue and submit the case for review to the MSU. At that time if a conflict in the delivery of service (s) will occur, the MSU escalated issues team will work with the Case Manager directly to ensure the Service Plan Goals provide detail and clarity to address the conflict in the Case Management and provider provision of service, and to ensure the Case Manager documents the service need as addressed in the conditions of provider participation, to alleviate and mitigate the potential for the conflict to have an untoward outcome, and assure appropriate safeguard for the Member.

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

Quality of service delivery performance of all providers is monitored by by the MSU (Quality Assurance/Improvement, Resource Center/Escalated Issues and Provider?). Individualized reports for provider complaint/incident are produced for complaints/incidents tracking. These reports are utilized to identify patterns of

incident or problem types requiring attention or patterns of complaints/incidents that may alert the MSU 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 the member's 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.

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 MSU 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) Upon receipt of an ADvantage referral from the Medicaid Services Unit (MSU), the case management supervisor assigns a case manager to the member. When the assignment is received, 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, MSU and DHS in the program), and review, update and complete the UCAT assessment, and discuss service needs and ADvantage service providers. The Case Manager notifies in writing the member's 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) In accordance with DHS Policy (317:35-17-14), the case manager completes and submits to the MSU an individualized service plan for the member, signed by the member and the case management supervisor. The case manager completes and submits to the MSU 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 MSU at least 30 calendar days before the end date of the existing service plan. In accordance with DHS policy (317:35-17-14), 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 MSU 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 MSU for resolution. In addition, based on the UCAT and/or case progress notes that document chronic uncooperative or disruptive behaviors, the LTC nurse or MSU may identify members that require MSU intervention.
(4) The case manager submits the care plan and service plan to the case management supervisor for review. In accordance with OAC 317:35-17-14, the case management supervisor documents the review/approval of the plans of receipt from the case manager or returns the plans to the case manager with notations of errors, problems, and concerns to be addressed. In accordance with OAC 317:35-17-14, the case manager re-submits the corrected care plan and service plan to the case management supervisor. The case management supervisor returns the approved care plan and service plan to the case manager. In accordance with OAC 317:35-17-14, after receiving supervisory approval, the case manager forwards, via postal mail, a legible copy of the care plan and service plan to the MSU. 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 MSU 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 MSU 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) In accordance with OAC 317:35-17-14, the case manager ensures providers are in receipt of the copies of the authorized service(s) by communicating with the service plan providers to facilitate service plan implementation. Within five working days of notification of an initial or new service plan authorization, the case manager contacts the member via the member’s chosen method of communication to and evaluate service plan implementation.
(6) The case manager contacts the Member to monitor and evaluate the adequacy of the service plan on the following minimum schedule:
(A) Within 5 working days of receipt of an authorized service plan for new and/or revised ADvantage services, sends the member a copy of the service plan or computer-generated copy of the service plan, copy of approved service plan goals and evaluate service plan implementation;
(B) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and
(C) 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 MSU. The MSU 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.

DHS Medicaid Services Unit (MSU) 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 Manger 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 DHS Medicaid Services Unit (MSU) 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.
• Documentation of potential abuse, neglect or exploitation.
• 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.
• Significant environmental hazards are identified by assessor.
• Requests for excessive personal care and / or ASR service.
• No Backup Plan.
Service Plans with any of the above indicators are forwarded for a clinical review by a registered nurse. Plans are then reviewed in detail for addressing identified indicators. 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 the case management service authorization requesting documentation to address those issues; The case management provider must submit revised documentation to address issues of concern in order for case management services to be approved for reimbursement.

• Identified issues are significant enough to warrant escalation to Escalated Issues Team. An Escalated Issues team member investigates the issue by contacting the case manager. Collaboration then occurs between team members and departmental management to ensure issues are appropriately addressed or resolved. When necessary, issues are forwarded to the ADvantage Ethics of Care Committee for guidance and/or administrative determinations.

Because members are supported in their own private residence or other settings where staff are not continuously available, all members are required to have back-up plans that include a minimum of 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 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 the assessment for medical eligibility, the DHS-MSU 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 educates the member and family that providers of Case

Management services may not provide any other ADvantage services in order to avoid a conflict of interest. The LTC nurse documents the names of the chosen agencies and the agreement of the member (by dated signature) to receive services provided by those agencies. If the member or his/her legal representative declines to make a provider choice, the LTC nurse documents the declination. If the Member has not made a selection for either Case Management, Home Care or both, the MSU 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, in keeping with conflict free requirements. With referral to the Case Management Agency, The MSU provides to the Case Management Agency the name of the Home Care agency selected by the member or identified through the rotating system.

After completing the in-home assessment and 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 The member, in consultation with the Case Manager, then selects an appropriate provider to deliver each service, according to conflict free requirements.

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 DHS Medicaid Service Unit (MSU) authorizes the individual service plan and all service plan amendments for each ADvantage member using protocol and criteria established by the Medicaid Agency. The MSU Service Plan Authorization unit (SPA) reviews/authorizes the initial service plan for each member enrolled in ADvantage. In addition, the MSU/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, submitted by the member's Case Manager and based upon member assessed need.

Service Plans with any of the risk factors identified in Appendix D-1 are forwarded for clinical review by a registered nurse. Plans are then reviewed in detail to ensure identified risk indicators are addressed in the member's Service Plan Goals. Outcome of the reviews is the same as noted in Risk Assessment and Mitigation.

When the MSU/SPA verifies member ADvantage eligibility, plan cost effectiveness that service providers are ADvantage authorized and Medicaid contracted, that the delivery of ADvantage services is consistent with the member's assessed need and that all identified risk factors have been addressed, the service plan is authorized.
MSU/SPA staff document authorized service plans on the Waiver Management Information System (WMIS). Prior Authorizations are generated from WMIS for individual services and posted on the Medicaid Management Information System.

All waiver service plans are subject to review and approval by both the DHS/MSU (the operating agency) and the Waiver Administration and Development department of the Oklahoma Health Care Authority (the Medicaid agency). Oklahoma Health Care Authority (OHCA) does not review and approve waiver service plans prior to implementation; however, all are subject to the Medicaid Agency's approval. DHS/MSU 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**
- ☑ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

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 contacts the member via the member's chosen method of communication to and evaluate 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 required 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 a 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 the unmet needs of the member. Additionally, depending on the nature of the problem discovered, the Case Manager engages APS and/or the MSU Escalated Issues Unit for assistance in issue resolution.

MSU- Escalated Issues 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:*

Case Management providers may not provide case management and other waiver services including, but not limited to, personal care, nursing and/or specialized medical equipment and supplies. The member has choice of provider for each service that is needed and the CM is obligated to honor member choice. The best interest of the participant is safeguarded by this arrangement because the arrangement allows the appropriate checks and balances. In the event the Member lives in an area in which no other alternative provider is available to provide services in the county of residence, the Case Manager will document the issue and submit the case for review to the MSU. At that time if a conflict in the delivery of service (s) will occur, the MSU escalated issues team will work with the Case Manager directly to ensure the Service Plan Goals provide detail and clarity to address the conflict in the Case Management and provider provision of service, and to ensure the Case Manager documents the service need as addressed in the conditions of provider participation, to alleviate and mitigate the potential for the conflict to have an untoward outcome, and assure appropriate safeguard for the Member. The State has established the following safeguards to ensure that service plan monitoring 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. 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.
3. At a systems level, the MSU maintains a Resource Center and Escalated Issues team to register member, member family or provider/case manager complaints, problems or incidents. The Resource Center 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 MSU assignment of Escalated Issues team to investigate, track resolution process and record actions and resolution for each complaint or incident.

4. Quality of service delivery performance of all providers is monitored by the MSU (Provider Audits, Resource Center/Escalated Issues team 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 MSU of potential quality problems with individual providers. MSU shares complaint/incident reports resulting from all

sources and including Provider Audit reports with the OHCA and the OHCA participates in Quality Management Strategies Council (QMSC) 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) and personal goals, 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) and personal goals, have been addressed Denominator: All members evaluated

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

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

	☐ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate Random sample
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

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:

Waiver Management Information System (WMIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and 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):
Other
If 'Other' is selected, specify:
Waiver Management Information System (WMIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 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:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and 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
If 'Other' is selected, specify:
Waiver Management Information System (WMIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and Percent of member 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:

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

collection/generation *(check each that applies):*		
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Proportionate Random sample
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: 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:
ELDERS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and 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):
Other
If 'Other' is selected, specify:
WMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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:

DHS Level of Care, Service Plan Authorization and Provider Audit teams 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 DHS 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 DHS NPAA will be required to submit, within five working days of request, a corrective action plan to the DHS MSU 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 DHS ADvantage Nursing Programs Assistant Administrator (NPAA) for Service Plan Authorizations contacts directly for resolution the Provider and appropriate DHS staff and, if deemed necessary, the Nursing Programs Assistant Administrator (NPAA) 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 MSU. 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 DHS.
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 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 DHS MSU Programs Assistant Administrator for Quality Assurance/Improvement 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 2 months to the MSU Quality Assurance/Improvement department. At the conclusion of a corrective action cycle, the MSU Provider Audit team performs a follow up audit of the Provider.
Quarterly, DHS 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)

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

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, Optional Expense Account for good and services, and Administrative Financial Management Services that enable an individual in need of assistance to reside in their home and in 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, within a range allowing for meaningful discretion of the Member;

• Supervises employee work time and approves all hours paid to PSAs/APSAs for work performed; 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 MSU 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. DHS is the IRS Fiscal Agent for the CD-PASS program and contracts through a Request for Proposal (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 MSU, 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 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, an Personal Emergency Response System (PERS) may be authorized as an additional backup alert for emergency assistance;
The MSU 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:

• 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 MSU 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; in addition, CDA/CM and 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.

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 MSU 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 MSU for ADvantage enrollment and service plan development, the MSU mails to the member's home address a CD-PASS service option brochure.

The CD-PASS service option brochure 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 MSU-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 MSU 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 MSU 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.

MSU will provide the Member with Employer and Employee Handbook, covering roles and responsibilities, explaining enrollment packets, service plan process, scheduling, program rules and limitations, prevention of abuse, neglect, and exploitation.

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 MSU 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 MSU 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.

Waiver Service	Employer Authority	Budget Authority
Consumer-Directed Personal Assistance Supports and Services	☑	☑

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**

- [x] **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:

- [x] **FMS are provided as an administrative activity.**

Provide the following information

i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

DHS Medicaid Services Unit 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 DHS 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:

DHS 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:

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

Specify:

Administrative Financial Management Services may include assistance with employer responsibilities. In addition, FMS provides to the member, in the form of training materials, verbal and/or written instruction, and training events, 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:

- [x] **Maintain a separate account for each participant's participant-directed budget**

- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **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:

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

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.

DHS 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, DHS and OHCA staffs participate in monthly teleconference calls with FMS contracted entity to review management reports and review issues related to contracted responsibilities. DHS MSU 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. DHS and OHCA regularly review FMS contracted entity performance of contracted responsibilities during quarterly Quality Strategy Council or during LTSS Council meetings. Annually the DHS Contract Manager submits a summary Professional Services Evaluation report on PPL performance to the DHS 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)*:

- [x] **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 Consumer Direction 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 MSU 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 MSU 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):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Prescribed Drugs	☐
Consumer-Directed Personal Assistance Supports and Services	☐
Respite	☐
Institution Transition Services	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
	☐
Skilled Nursing	☐
Personal Care	☐
Environmental Accessibility Modifications	☐
Personal Emergency Response Systems	☐
Adult Day Health	☐
Advanced Supportive/Restorative Assistance	☐
Assisted Living Services	☐
Specialized Medical Equipment and Supplies	☐
Case Management	☑
Hospice Care	☐
Home-Delivered Meals	☐
Nursing	☐
Therapy Services	☐

☑ **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 DHS or by the contracted fiscal sub-agent. The FMS provides to the member, in the form of training materials, verbal and/or written instruction, and training events, 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.

DHS 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.

DHS 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, DHS and OHCA staffs participate in monthly teleconference calls with FMS contracted entity to review management reports and review issues related to contracted responsibilities. DHS MSU 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. DHS and OHCA regularly review FMS contracted entity performance of contracted responsibilities during quarterly Quality Management Strategy Council or during LTSS Council meetings. Annually the DHS Contract Manager submits a summary Professional Services Evaluation report on PPL performance to the DHS 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:

The member may designate an "authorized representative" to assist them with their employer and budgetary 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 (including filing complaints, grievances, and Fair Hearings). 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 MSU 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. At the point when an "authorized representative" has legal decision-making authority, the member may appoint a second authorized representative to advocate on the member's behalf.

As a part of the service planning process, the need for an "authorized representative"/independent advocate is assessed by the Interdisciplinary Team (including the member and the CDA/CM) 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 MSU at the annual service plan reassessment.

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 DHS; 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

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		1518
Year 2		1573
Year 3		1607
Year 4		1633
Year 5		1654

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Cost of criminal background investigations are incorporated in the Member/Employer's budget as an allowable expenditure for necessary goods or services.

- [x] **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**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **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:

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**
- [x] **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 MSU 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 MSU 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 MSU 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 MSU, 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.

MSU reviews utilization monthly based on hours authorized per week and notifies Members that are exceeding those authorizations. Members are advised of their authorized amount and informed of their responsibilities to remain within these amounts. FMS and CDA/CM assistance is available to all Members in need of counseling and guidance. If a Member refuses or is unable to supervise service utilization, the Member's case will be reviewed by the Ethics of Care Committee (EOCC) and may be returned to agency care through an EOCC determination.

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 DHS nurse explains to the member (and/or his/her legal representative) his/her rights to a Fair Hearing) 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 Member Consents and Rights Form. 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 DHS in completing this application or in obtaining required verification
• reapply at any time benefits stop
• receive information about programs administered by DHS.

The member is informed by the DHS 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 (DHS)

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).

DHS manages a statewide complaint/concern discovery and remediation system for the Medicaid Services Unit (MSU) CareLine that offers timely response to grievances/complaints. Through a toll-free 1-800 telephone number, the Resource Center 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 is designed to help safeguard the health and safety of members served through the ADvantage Program. The Resource Center receives all initial Member phone inquiries, resolves routine issues, and forwards the complex or critical issues to the Escalated Issues team for research and resolution. Each complex or critical complaint call is assigned to the Escalated Issues team to research

the issue and work collaboratively with all parties as needed to facilitate resolution of the issue. As part of their orientation to the ADvantage Program, members are instructed to call the 1-800 telephone number with complaints, concerns or requests for information. The member is informed that filing a grievance or making a complaint through the Resource Center 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 the 800 telephone number, resolution may be achieved without need for a fair hearing. Tthe Resource Center utilizes a system to categorize/subcategorize complaints and identifies areas in the system for potential quality improvement activities. Escalated Issues team follows established timelines for prompt resolution depending on the category/subcategory of the issue. The Escalated Issues staff follows up on all issues until resolution is achieved. The major types of grievances/complaints that are resolved 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 staff 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 staff for action/ resolution. As back -up, issue escalated to Director of Programs if Clinical staff 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 – 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 and the Escalated Issues teams database provide 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 and the Escalated Issues teams 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 MSU on the appropriate form within one business day. The following critical incidents must be reported to the MSU: 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 MSU Escalated Issues team, 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 (DHS) 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: "Infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement or mental anguish" (O.S. 43A § 10-103. A.8).

Financial Neglect: means repeated instances by a caretaker, or other person, who has assumed the role of financial management, of failure to use the resources available to restore or maintain the health and physical well-being of a vulnerable adult, including but not limited to:
a. Squandering or negligently mismanaging the money, property, or accounts of a vulnerable adult
b. Refusing to pay for necessities or utilities in a timely manner, or
Providing substandard care to a vulnerable adult despite the availability of adequate financial resources (O.S. 43A § 10-103. A.10).

Neglect means:
a. The failure to provide protection for a vulnerable adult who is unable to protect his or her own interest,
b. The failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or
Negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; (O.S. 43A § 10-103. A.11).
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 representative 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 make a reportas 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, "persons required to make reports pursuant to this section shall include, but are not limited to, physicians; operators of emergency response vehicles and other

medical professionals; social workers and mental health professionals; law enforcement officials; staff of domestic violence programs; and long-term care facility personnel." Other examples may include staff of nursing facilities, intermediate care facilities for persons with mental retardation, assisted living facilities, and residential care facilities, other health care professionals; persons entering into transactions with a caretaker or other person who has assumed the role of financial management for a vulnerable adult; staff of group homes, or employment settings for individuals with developmental disabilities, job coaches, community service workers, and personal care assistants; and municipal employees.

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 MSU 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 MSU Escalated Issues team 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 MSU Escalated Issues team reviews all critical incident reports and determines whether the appropriate response to each incidence occurred. The MSU coordinates their investigation and response efforts with governmental investigative authorities as required by State or Federal law. The MSU 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 DHS Medicaid Services Unit (MSU) for the ADvantage Program operates a toll free telephone number (1-800-435-4711) for inquiries or complaints from members, providers, or others. MSU staff report any suspected incidence of abuse, neglect or exploitation to APS.

The Oklahoma Department of Human Services website for Adult Protective Services 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, and 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. The report shall contain the following information:
a. The name and address of the vulnerable adult
b. The name and address of the caretaker, guardian, or person having power of attorney over the vulnerable adult's resources if any,
c. A description of the current location of the vulnerable adult,

d. A description of the current condition of the vulnerable adults, and
e. A description of the situation which may constitute abuse, neglect or exploitation of the vulnerable adult.

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 (COPP), 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 MSU CareLine 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 MSU Escalated Issues team reviews reports of critical events or incidents including suspected abuse, neglect or exploitation. When instances of potential abuse, neglect and exploitation are identified, these instances are immediately reported to Adult Protective Services.
Adult Protective Services (APS) is a program within the Oklahoma Department of Human Services (DHS) 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 adults 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 CommunityAPS@okdhs.org, 1-800-522-3511 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 in 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 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. 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 DHS 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 MSU 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 MSU Escalated Issues team 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 (DHS) Adult Protective Services (APS) 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 DHS 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 DHS web link of CommunityAPS@okdhs.org,, 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 DHS Adult Protective Services for further investigation. Results, including progression to the caregiver being placed on the Department's Community Services Worker Abuse Registry, are communicated to DHS and the Provider Agency that employs the paid caregiver.

During provider audits, the DHS Quality Assurance/Improvement 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 MSU 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 MSU 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 and the Escalated Issues team: Reports of or concern about a member's health and welfare are referred to or received by the Resource Center and/or the Escalated Issues team. Any person can call the 1-800 number including -- members, family members, providers, state agencies, or any other individual. The Resource Center 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 Escalated Issues team supervisory staff for immediate assignment to Escalated Issues team for verification of APS notification and to provide additional information as necessary. The Escalated Issues team categorizes under either ADvantage Policy and Procedure, Provider Policy and Procedure, Health & Safety, Member Services, APS Intervention, Critical Incidents, Systems Issues or Other Escalated Issues, for tracking and resolution.

Critical Incidents: Providers utilize the Critical Incident report form to report serious issues to the Medicaid Services Unit (MSU). Those incidents that require follow up by the Escalated Issues team are tracked and resolved by the team. Critical Issues are categorized as Medication Error Requiring Medical Attention, Falls or Injuries Requiring Medical

Attention, Loss of Residence Due to Disaster, Suicide Attempt, Questionable Unexpected Death, Interruption of Needed Medical Supports, Unable to Contact Member, Sexual Abuse, Physical Abuse, Neglect, Exploitation, Use of Restraints, or Self-Neglect.

Provider Question E-Mail: All ADvantage Program providers may notify Medicaid Services Unit (MSU) of potential abuse, neglect and exploitation via a secured e-mail at aauproviderquestions@aau.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 Escalated Issues team supervisory staff for notifying APS immediately.

Morbidity 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 MSU 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 MSU Provider Audit team conducts onsite provider performance audits, off-site financial/staff 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/), "The Nurse 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; … (7) provide public education."

The DHS MSU provides oversight of the reporting of and response to any critical incidents. MSU 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 MSU 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 the health and safety, including abuse neglect and exploitation. MSU 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 MSU'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 team and Provider ? offer continuous public access for reporting of abuse, neglect or other health and safety concerns, although staffing for handling messages left by phone (Reception/Resource Center) or via e-mail is 8AM to 5PM weekdays. Mortality and Morbidity (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:

DHS Adult Protective Services (APS) is the designated state agency responsible for investigating any report of unauthorized use of restraints or 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.

Medicaid Services Unit (MSU) 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 seclusion 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:

DHS Adult Protective Services (APS) 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.

MSU 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:

DHS Adult Protective Services (APS) is the designated state agency responsible for investigating any report of unauthorized use of restraints or 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.

Medicaid Services Unit (MSU) 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 seclusion 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:

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 and 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.

DHS, 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 to assure 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 DHS within 30 days of survey completion. As these reports are received, DHS shares the findings with the Quality Management Strategies Council (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 who 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) Medication error incident reports.
(4) 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 who 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 DHS within 30 days of survey completion. As these reports are received, DHS shares the findings with the Quality Management Strategies Council (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.

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
Number and 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:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percentage of members receiving education on ANE, protections, and how to report instances through Service Planning and on-going monitoring process
Numerator: Number of members receiving education on ANE, protections, and how to report instances through Service Planning and on-going monitoring process
Denominator: Total number of members with service plans reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Management Information System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other**	☑ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and 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):
Program logs
If 'Other' is selected, specify:
Waiver Management Information System (WMIS) and Escalated Issues (EI) Tracking Logs

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

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percentage of Providers who received education on ANE, and how to report instances. Numerator: Number of Providers who received education on ANE, and how to report instances. Denominator: Total number of Providers

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

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and 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
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and Percentage of members with reported use of restrictive intervention (including restraints and seclusion) for which allegation of restrictive intervention usage was resolved in accordance with state policy. Numerator: Number of Member APS referral regarding use was resolved per policy Denominator: Total number of Member APS referrals regarding use of restrictive interventions

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Number and percentage of Members monitored having overall positive account of the services, based on established overall health care standards including planning, delivery, and quality of care. Numerator: Number of Members monitored having overall positive account of the services, based on established overall health care standards Denominator: Number of Members monitored

Data Source (Select one):
Participant/family observation/opinion
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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 Ethics of Care Committee (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 MSU Provider Audit team monitors to ensure that members received education from Case Managers on how to report abuse, neglect and/or exploitation. If any instances are found that a member has not received education on how to report abuse, neglect and exploitation, the DHS MSU Quality Assurance/Improvement staff 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 2 months to the Quality Assurance/Improvement department. At the conclusion of a corrective action cycle, the MSU Provider Audit team performs a follow up audit of the provider.

MSU Escalated Issues team monitors that all member complaint investigations were initiated within the 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 team initiates planning with the member, the Case Manager, Adult Protective Services and others to facilitate member safeguards in the 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 MSU ADvantage Programs Assistant Administrator for Provider/Member Relations contacts directly

for resolution the Provider and/or appropriate DHS 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 MSU ADvantage Administration.

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

ii. **Remediation Data Aggregation**

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

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

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 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 Strategies Council (QMSC) collaborates for the trending, prioritizing and implementation of system improvement. The Council consists of senior level staff and Quality Assurance/Quality Improvement leadership from OHCA, DHS 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, DHS 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

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 DHS MSU Programs Assistant Administrators, the DHS Level of Care Determination Unit Nurse Programs Assistant Administrators, the OHCA Audit and Program Integrity Management Division and the DHS Quality Assurance and Improvement department (which includes the MSU Provider Audit team), 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 DHS MSU Executive and State Office Executive staff and OHCA Waiver Administration and Development staff. A Quality Management Strategy Council (QMSC) 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, DHS generates the ADvantage Cumulative Report which reports key demographic and process program measures. The report is distributed to administrative leadership within DHS, OHCA and to representatives of Member advocacy and Provider groups.

Quarterly the 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 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 quarterly meetings and shared with unit Program Assistant 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 Aging Services – Citizens Advisory Panel, members of the state legislature, and is posted on the OHCA and DHS websites for access by service members and their families, advocates, and members of the general public.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☑ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

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. 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 Aging Services Citizens Advisory Panel, members of the state legislature, and is posted on the OHCA and DHS 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 Strategies 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 MSU 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: MSU-Tulsa
Communication: Report of financial audit to provider includes findings and recommendations/requirements for plan of correction/improvement 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.

The entity that is responsible for the independent audit under the Single Audit Act in Oklahoma is the Office of the State Auditor and Inspector. This agency performs annual audits separately and apart from the operating agency (DHS) and the Medicaid agency (OHCA.)

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
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 providers that use the EVV system for financial management and recordkeeping practices as required by State policy. Numerator: Total of providers that used the EVV for financial management and recordkeeping

practices through the EVV system for in-home services. Denominator: Total of providers that provide in-home services.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

Performance Measure:
Number and percentage waiver claims paid for ADvantage services to members with rates consistent with the approved rate methodology. Numerator: Paid claims for ADvantage services to members with rates consistent with approved rate methodology Denominator: Paid claims for ADvantage waiver services

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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 reimbursements for claims found to have been inappropriately paid are recouped from providers.

Quarterly, DHS will provide reports of remediation and corrective action plans (if any) to the Quality Management Strategies Council (QMSC) and to the OHCA Director of Waiver Administration and Development.

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

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

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

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 DHS websites.

1) Rates for waiver services are set by one of the methodologies below: 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; Re-modelers and Builders. Further, each required environmental modification is different. For example, ramps costs (due to the initial conditions of the home and yard) differ according to such variables as the length of the ramp, types of rails, and strength of the ramp needed if, for instance the member has an electric wheelchair.
b) Consumer-Directed Personal Supports and Services Methodology for these rates include 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 services assistance or advanced personal services assistance. 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. DHS 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.**
- **This waiver is a part of a concurrent □1115/□1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The □1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

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 DHS is responsible for providing State share funding for all Waiver services except "prescription drugs in excess of State Plan coverage limits" and receives Legislative Appropriations to cover the same. The OHCA is responsible for providing State share funding for "prescription drugs" covered under the various Waivers and receives Legislative Appropriations to cover the same.

On a weekly basis, the OHCA submits a billing to the DHS for the State share dollars for all Waiver services (except "prescription drugs") for which 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".

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**
  Check each that applies:
  - [ ] **Appropriation of Local Government Revenues.**

    Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

  - [ ] **Other Local Government Level Source(s) of Funds.**

    Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**
  Check each that applies:
  - [ ] **Health care-related taxes or fees**
  - [ ] **Provider-related donations**
  - [ ] **Federal funds**

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

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 I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☑ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

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

All 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.

Some waiver recipients, who have elected the Assisted Living service option, may pay a vendor co-payment to the facility, depending on their income.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

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

Waiver Service	Charge
Prescribed Drugs	**Amount:** $0.00 for preferred generics. $0.65 for cost of $0.00-$10.00 $1.20 for cost of $10.01-$25.00

Waiver Service	Charge
	$2.40 for cost of $25.01-$50.00 $3.50 for cost of $50.01 or more **Basis:** $0.00 for preferred generics. $0.65 for prescriptions having a Medicaid allowable payment of $0.00-$10.00. $1.20 for prescriptions having a Medicaid allowable payment of $10.01-$25.00. $2.40 for prescriptions having a Medicaid allowable payment of $25.01-$50.00 and $3.50 for prescriptions having a Medicaid allowable paynment of $50.01 or more. Co-payments are for members 21 and older.
Assisted Living Services	**Amount:** Amount Varies with COLA **Basis:** Total counted income (Gross Income minus Medicaid Income Pension Trust). MINUS assisted living maintenance standard (150% of SSI Federal Benefit Rate). MINUS Medicare premium and heal