

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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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

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

- The deletion of Home Health Care service
- Provider qualifications of Dental, Occupational Therapy, Physical Therapy, Speech and Nutrition services updated to require a current SoonerCare General Provider Agreement with the Oklahoma Health Care Authority.
- The Quality Management Strategy has been updated and integrated into waiver application version 3.5 format.

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

### 1. Request Information (1 of 3)

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- 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*):  
**In-Home Supports Waiver for Adults**
- 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.0343

**Waiver Number:**OK.0343.R03.00

**Draft ID:** OK.01.03.00

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

Regular Waiver

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

07/01/12

**Approved Effective Date:** 07/01/12

## 1. Request Information (2 of 3)

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

**Hospital**

Select applicable level of care

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

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

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

**Nursing Facility**

Select applicable level of care

**Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

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

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

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

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

## 1. Request Information (3 of 3)

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

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

**§1915(b)(2) (central broker)**

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

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

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

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

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

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

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

Specify the program:

#### H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

## 2. Brief Waiver Description

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

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

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

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

The Quality Assurance Unit of OKDHS/DDSD monitors quality of services provided and monitors the satisfaction of the persons served. The OHCA audits the plans of care to ensure services are being provided in the manner required by policy.

## 3. Components of the Waiver Request

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**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

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- 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. Statewidness.** Indicate whether the State requests a waiver of the statewidness requirements in §1902(a)(1) of the Act (*select one*):
- No**
- Yes**

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

- Geographic Limitation.** A waiver of statewidness 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 statewidness 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

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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

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*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:

A statutorily based Board, the Advisory Committee on Services to Persons with Developmental Disabilities (ACSPDD), reviews and approves all policy and provides feedback and recommendations regarding all policy changes. This Board includes members and their advocates. The Governor's Conference on Developmental Disabilities, held annually, routinely holds public forums related to services.

In addition, the following public input has been obtained with respect to this waiver renewal.

Tribal Consultation occurred at the November 1, 2011, regularly scheduled meeting that OHCA hosts with IHS, Tribal and Urban Indian facilities. OHCA's Waiver Administration Director Melinda Jones was on the agenda to discuss with the participants the plans to renew the In-home Supports Waivers for Children and Adults. Participants were interested in knowing if these waivers have any special impact on tribal members or facilities. Ms. Jones reinforced that the waivers serve members from all demographic groups and are always open to visiting with the tribes about home-based services they could provide under the waivers. No additional comments were received in writing following the meeting.

The OHCA on February 17, 2012, published the proposed waiver renewals and a "feedback" form for public comments. No public comments were received.

On February 24, 2012, the Developmental Disabilities Services Division of the Oklahoma Department of Human Services, the operating agency for the waiver, sent an e-mail communication to all waiver providers requesting review of the draft waiver renewal that was posted on the OHCA web page. Providers were invited to submit comments on a feedback form that was available with the waiver language. One comment was received. However, it was not feedback about the waiver. Rather, a provider sent a question regarding the information needed on an operational form.

**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)

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

**Last Name:**

Jones

**First Name:**

Melinda

**Title:**

Director, Waiver Administration and Development

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:**

**Zip:** **Oklahoma**

**Phone:**

**Fax:**  **Ext:**   **TTY**

**E-mail:**

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Oklahoma**

**Zip:**

**Phone:**  **Ext:**   **TTY**

**Fax:**

**E-mail:**

**8. Authorizing  
Signature**

Kristi.Blackburn@okdhs.org

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:**

Mike Fogarty

State Medicaid Director or Designee

**Submission Date:**

Jun 12, 2012

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

**Last Name:**

Splinter

**First Name:**

Garth

**Title:**

State Medicaid Director

**Agency:**

Oklahoma Health Care Authority

**Address:**

2401 N.W. 23rd, Ste. 1-A

**Address 2:****City:**

Oklahoma City

**State:****Oklahoma****Zip:**

73107

**Phone:**

(405) 522-7365

Ext:   TTY**Fax:**

(405) 530-3218

**E-mail:****Attachments**

garth.splinter@okhca.org

**Attachment #1: Transition Plan**

Specify the transition plan for the waiver:

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

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

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

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

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

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

**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, Developmental Disabilities Services Division

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

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### 2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:  
**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

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

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

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

Responsibilities afforded to OHCA as related to fiscal matters are outlined in Oklahoma Administrative Code (OAC) 317:30. OHCA establishes all rates for waiver services. OHCA monitors waiver expenditures and enrollment monthly using data in the MMIS. In addition, a SoonerCare Fast Facts on Home and Community-Based Services Waivers is published quarterly along with a monthly Waiver Administration Fast Facts. These documents are presented by the State Medicaid Director in monthly meetings of the OHCA Board.

The OHCA Level of Care Evaluation Unit (LOCEU) conducts the initial screening/evaluation to determine or confirm a member's level of care, including verifying a diagnosis of mental retardation, and approves/denies waiver eligibility. OKDHS/DDSD Case Management Supervisors perform re-evaluations unless a significant change occurs which questions the qualifying diagnosis of a member. When a significant change affecting the member's qualifying diagnosis is suspected, Case Managers gather necessary documentation and submit to OHCA LOCEU to determine level of care.

OKDHS/DDSD conducts an audit which specifically includes a review of re-evaluations and reports findings to OHCA. OHCA representatives participate in a Quality Management Committee, along with staff of DDSD. The Quality Management Committee meetings include review of discovery and remediation activities for the indicators in the Quality Improvement Strategy including those for the level of care and end of year summary data for all quality indicators. Quality Management Committee meetings also include discussion of any identified issues or trends and suggestions for systems or other remediation or improvements.

OKDHS/DDSD gathers information to verify non-licensed provider applications meet provider qualifications

prior to submission to OHCA for final provider Agreement approval.

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

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

OKDHS/DDSD monitors non-licensed providers for compliance and provides results to OHCA. OHCA is notified when Administrative Inquiries and follow-ups as well as annual performance reviews and follow-ups are completed. OKDHS/DDSD Quality Assurance Unit also monitors the performance of OKDHS/DDSD by conducting performance reviews of OKDHS/DDSD member records to ensure member services are provided in an amount, duration and frequency which supports member Plans. Results of OKDHS/DDSD Case manager reviews are sent by email to OHCA. OKDHS/DDSD Quality Assurance provider documents are posted to a web-based system upon completion. The web-based system may be accessed by OHCA at any time. OHCA representatives are included in the Quality Management Committee to review quality indicators. Follow-ups are sent to OHCA as they are completed.

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

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

## Appendix A: Waiver Administration and Operation

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**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.*

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

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

## Appendix A: Waiver Administration and Operation

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

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

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

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

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

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

## Appendix A: Waiver Administration and Operation

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**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:

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

## Appendix A: Waiver Administration and Operation

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**6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative

functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

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

## 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
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 administrative reports (denominator) furnished within 10 working days of the close of the quarter to the State Medicaid Director and Waiver Administration Unit (numerator).**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Report prepared by OKDHS/DDSD**

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

	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

Number and percent of member records reviewed by OKDHS/DDSD and reviewed by OHCA (denominator) where member Plans included a description of each of the services and supports included in the member's plan of care, including the amount, duration, and frequency of service (numerator).

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**Operating agency performance monitoring (Area Survey Q7b)**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input type="checkbox"/> <b>Other</b>	<input type="checkbox"/> <b>Annually</b>	

Specify: <input type="text"/>		<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and percent of member's records reviewed by OKDHS/DDSD and reviewed by OHCA (denominator) for whom a Team, as described in Appendix D-1:c, meeting was held within 30 days of the identification or notification of the need for change in authorization of waiver services (numerator).

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**OKDHS/DDSD report**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

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

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**OKDHS/DDSD report**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of waiver members (denominator) who received an annual reevaluation of eligibility by OKDHS/DDSD and were reported to OHCA within 12 months of their initial level of care evaluation or within 12 months of their last annual level of care evaluation (numerator).**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**OKDHS/DDSD report**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="text"/>	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**  
**Number and percent of provider Agreement applications for non-licensed providers approved and reviewed by OHCA (denominator) for which OKDHS/DDSD verified provider information prior to verification by OHCA and initiation of provider Agreement (numerator).**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**OKDHS/DDSD report**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of fixed service rates submitted to OHCA (denominator) and approved for OKDHS/DDSD by the OHCA Board of Directors (numerator).**

**Data Source** (Select one):

**Program logs**

If 'Other' is selected, specify:

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

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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

Number and percent of rules pertaining to OKDHS/DDSD waiver members submitted to (denominator) and approved by OHCA (numerator).

Data Source (Select one):

Program logs

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 50%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other

		Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of required provider performance monitoring reviews (denominator) conducted by OKDHS/DDSD and reported to and reviewed by OHCA (numerator).**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**OKDHS/DDSD report**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

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

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	

		<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of monthly prior authorization reports (denominator) submitted to and reviewed by OHCA that are within approved levels (numerator).**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

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

<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- 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 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. OHCA will maintain administrative authority through the use of an electronic database designed for storing information received related to problems identified and resolution of these matters. The OHCA contract monitor will be directly responsible for mediating any individual problems pertaining to administrative authority. The OHCA contract monitor will work with the designated contractor point of contact to resolve any problems in a timely manner. The OHCA contract monitor will have the use of penalties and sanctions in accordance with the terms of the contract. Problems requiring additional OHCA staff will be addressed in work groups involving appropriate personnel to resolve issues timely and effectively. These problems and resolutions will also be reported in the Quality Management Committee meetings.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**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
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Intellectual Disability	18		<input checked="" type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

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

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

Specify:

## Appendix B: Participant Access and Eligibility

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

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

- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished

to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

- Other**

Specify:

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

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

The In-Home Supports Waiver for Adults (IHSW-A) serves adults who live with family, friends or in their own home. The IHSW-A relies heavily on the use of natural and generic resources and supports. The support needs of the member must be able to be met through a combination of non-paid, non-waiver, SoonerCare resources available to the member, and with HCBS waiver resources that are within the annual limit. Additionally, for those members who are 18, 19 or 20 years of age, they receive the benefit of services available to them under the provisions of EPSDT. As such, any Waiver services that could be provided to these members under the provisions of EPSDT will be provided to them as State Plan Services and not as IHSW-A services.

The IHSW-A annual cost limit was first determined by an analysis of the costs of similarly situated members when the Waiver was initiated in State Fiscal Year (SFY) 1999. In subsequent operating years (Annual Reporting Periods), the annual cost limit was adjusted in conjunction with rate increases paid to service providers to ensure its continued relevance.

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

- The following dollar amount:**

Specify dollar amount:

**The dollar amount (select one)**

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

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- The following percentage that is less than 100% of the institutional average:**

Specify percent:

**Other:**

Specify:

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

The Annual Limit may be increased within a plan of care year for the following:

1. In the event of provider service rate increases occurring during a plan of care year resulting in individual plans of care exceeding the annual limit. The annual limit may be increased for that plan of care year by the impact of the rate increases. The State submits an amendment to increase the individual cost limit when a rate increase occurs.
2. When Assistive Technology Services or Environmental Accessibility Services were ordered under a previous year's plan but not delivered or completed until the current plan of care year. The current plan of care may exceed the annual limit by the cost of the previously-authorized Assistive Technology Services or Environmental Accessibility Services.
3. To allow for major purchases in excess of \$2,500 of Assistive Technology Services or Environmental Accessibility Services, but not to exceed \$10,000 in any five year period.
4. To allow services authorized by the Oklahoma Department of Human Services (OKDHS) DDSD State Office to resolve time-limited emergency situations after all other resources have been exhausted.

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

**Other safeguard(s)**

Specify:

--

## Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1511
Year 2	1571
Year 3	1641
Year 4	1721
Year 5	1780

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (*select one*):
- The State does not limit the number of participants that it serves at any point in time during a waiver year.
  - The State limits the number of participants that it serves at any point in time during a waiver year.

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

Table: B-3-b

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

## Appendix B: Participant Access and Eligibility

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

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):
- Not applicable. The state does not reserve capacity.

- The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Furnish waiver services to individuals experiencing crisis per OAC 317:40-1-1	
Transition of members who age out of the In-Home Supports Waiver for Children	

## Appendix B: Participant Access and Eligibility

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

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

Furnish waiver services to individuals experiencing crisis per OAC 317:40-1-1

**Purpose** (describe):

Waiver services are made available for individuals experiencing crisis that pose risk to health and/or safety per OAC 317:40-1-1.

**Describe how the amount of reserved capacity was determined:**

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

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

Waiver Year	Capacity Reserved
Year 1	10
Year 2	15
Year 3	20
Year 4 (renewal only)	25
Year 5 (renewal only)	30

## Appendix B: Participant Access and Eligibility

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

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

Transition of members who age out of the In-Home Supports Waiver for Children

**Purpose** (describe):

To accommodate the transition of members who age out of the In-Home Supports Waiver for Children (IHSW-C) to ensure the continuity of their services.

**Describe how the amount of reserved capacity was determined:**

Reserved capacity is based on the number of In-Home Supports Waiver for Children (IHSW-C) members expected to age out and thus require the In-Home Supports Waiver for Adults (IHSW-A).

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

Waiver Year	Capacity Reserved
Year 1	40

Waiver Year	Capacity Reserved
Year 2	45
Year 3	50
Year 4 (renewal only)	55
Year 5 (renewal only)	60

## Appendix B: Participant Access and Eligibility

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

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

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

**e. Allocation of Waiver Capacity.**

*Select one:*

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

**a.**

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

- §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 4)

*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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.*

- 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 (*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-c (209b 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-c (209b 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-c (209b State). Do not complete Item B-5-d)*

**Appendix B: Participant Access and Eligibility****B-5: Post-Eligibility Treatment of Income (2 of 4)****b. Regular Post-Eligibility Treatment of Income: SSI 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 (3 of 4)****c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR 435.735 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 amounts 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):

- The following standard under 42 CFR §435.121**

Specify:

- 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 percentage:

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

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

Specify:

- The following dollar amount**

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

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

*Specify:*

- Other**

*Specify:*



---

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

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

**Specify the amount of the allowance** (*select one*):

- The following standard under 42 CFR §435.121**

*Specify:*

- 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 (4 of 4)

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

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

##### i. Allowance for the personal needs of the waiver participant

(select one):

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

Specify percentage:

- The following dollar amount:**

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

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

Specify formula:

**Other**

*Specify:*

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

Select one:

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

*Explanation of difference:*

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

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

Select one:

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

## **Appendix B: Participant Access and Eligibility**

### **B-6: Evaluation/Reevaluation of Level of Care**

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

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

**i. Minimum number of services.**

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

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

- The provision of waiver services at least monthly**

**Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

No minimum frequency

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

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

*Specify the entity:*

**Other**  
*Specify:*

The OHCA's Level of Care Evaluation Unit (LOCEU) staff perform all initial evaluations and they perform reevaluations where there appears to be a significant change which questions the qualifying diagnosis. All other annual reevaluations are conducted by OKDHS/DDSD Case Management Supervisors.

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

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

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

Information used to conduct an initial evaluation is submitted to OHCA by the OKDHS/DDSD Intake Case Manager. This information includes a psychological evaluation current within 12 months of requested approval date that includes a full scale functional and/or adaptive assessment and a statement of age of onset of the disability and intelligence testing that yields a full scale intelligence quotient; a social service summary current within 12 months of requested waiver approval date that includes a developmental history; a medical evaluation current within 90 days of requested waiver approval date; a completed ICF-ID Level of Care Assessment form; and proof of disability according to Social Security Administration (SSA) guidelines. If a disability determination has not been made by SSA, OHCA may make a disability determination using the same guidelines as SSA. Annual reevaluations are conducted by OKDHS/DDSD Case Management Supervisors unless a significant change has occurred which questions a member's qualifying diagnosis. In those cases, the same, but current, information used for the initial evaluation is submitted to OHCA for reevaluation. Relevant policy may be found at OAC 317:40-1-1.

**e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**  
 **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

The same process is used for reevaluation as the initial evaluation except the OKDHS/DDSD Case Management Supervisor is responsible for conducting routine reevaluations. The OHCA LOCEU conducts initial evaluations and reevaluations that question the qualifying diagnosis.

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

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

*Specify the other schedule:*

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

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

*Specify the qualifications:*

OHCA Level of Care Evaluation Unit staff must be a Qualified Mental Retardation Professional (QMRP) to perform initial evaluations of level of care for waiver applicants. To qualify as a QMRP a person must have a Baccalaureate Degree in a social science, behavioral science or human services field and have at least one year of experience working directly with persons with mental retardation or other developmental disability.

Annual reevaluations may be conducted by OKDHS/DDSD Case Management Supervisors. Requirements for an OKDHS/DDSD Case Manager consist of a Bachelor's Degree in a human services field and one year of experience working directly with individuals with developmental disabilities; or possession of a valid permanent Oklahoma license as approved by the Oklahoma Board of Nursing to practice professional nursing and one year working directly with individuals with developmental disabilities.

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

The OKDHS/DDSD generates a monthly report listing the names of members whose reevaluation is due in 120 days. These reports are provided to appropriate OKDHS/DDSD Case Management Supervisors and Case Managers for follow-up action. Case Managers also use a tickler file system to assure timely reevaluations are conducted. Additionally, the training for and practice of OKDHS/DDSD Case Managers is to prepare for reevaluation approximately 90 days prior to a member's annual Team, as described in Appendix D-1:c, meeting.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The OKDHS/DDSD Case Manager maintains these records and a copy is maintained in the OKDHS Central Records.

## **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**
- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percent of new enrollees (denominator) who had a level of care indicating the need for ICF-ID level of care prior to the receipt of services (numerator).**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

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

<b>collection/generation</b> (check each that applies):		
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input checked="" type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

**Performance Measure:**

**Number and percent of waiver members (denominator) who received an annual reevaluation of financial and level of care eligibility within 12 months of their initial level evaluation or within 12 months of their last annual reevaluation (numerator).**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

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

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percent of member's initial level of care evaluations (denominator) where required forms/instruments were completed by the State (numerator).**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

		<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of member's annual level of care reevaluations (denominator) where required forms/instruments were completed by the State (numerator).**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of initial level of care evaluations (denominator) with true negatives where level of care criteria was inaccurately applied (numerator).**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="text"/>	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**  
**Number and percent of annual level of care evaluations (denominator) with true negatives where level of care criteria was inaccurately applied (numerator).**

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

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

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and percent of initial level of care evaluations (denominator) made by a QMRP (numerator).

**Data Source (Select one):**

Record reviews, off-site

If 'Other' is selected, specify:

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

	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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.  
 Both the State oversight agency, OHCA, and operating agency, OKDHS/DDSD, share an electronic eligibility system which may be accessed by either party at any time. The operating agency follows up on each identified problem to ensure it is corrected. This may include directing case management to complete or gather required forms, ensuring the level of care was completed by a qualified person and following up to ensure the issue is corrected. Documents to support correction are maintained in files at OKDHS and available to OHCA at any time.
- ii. **Remediation Data Aggregation**

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

<b>Responsible Party(check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**c. Timelines**

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

- No  
 Yes

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

**Appendix B: Participant Access and Eligibility****B-7: Freedom of Choice**

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

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

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

When the OKDHS/DDSD determines an individual may require ICF-ID level of care, the individual or legal representative is informed of any feasible alternatives under the waiver and is given the choice to receive those services in an institution or through a HCBS Waiver. Evidence of this choice is documented initially and annually thereafter using the "Documentation of Consumer Choice" form that is provided to and signed by the individual or legal representative. This form gives the individual the choice between institutional care and HCBS and outlines the freedom to choose from any available provider of waiver services. OKDHS/DDSD Intake Staff inform potential members of the services available through the waiver and routinely provide this information through verbal communication and by providing informational pamphlets to potential waiver members and their legal representatives. The OKDHS/DDSD Case Manager provides a detailed explanation of the process for the authorization of waiver services and the Team, as described in Appendix D-1:c, process and is responsible for ensuring completion of the "Documentation of Consumer Choice" form. Additionally, OHCA policy, OAC 317:30-3-14, assures that any individual eligible for SoonerCare may obtain services from any institution, agency, pharmacy, person or organization that is qualified to perform the services.

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

The OKDHS/DDSD Case Manager maintains these forms and a copy is maintained in the OKDHS Central Records. The form is also scanned and electronically retrievable through the OKDHS/DDSD case management information system.

## Appendix B: Participant Access and Eligibility

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

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

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

OKDHS/DDSD employs bilingual Case Managers and OKDHS forms and pamphlets are available in Spanish.

## Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Services		
Statutory Service	Habilitation Training Specialist Services		
Statutory Service	Homemaker		
Statutory Service	Prevocational Services		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Extended State Plan Service	Prescribed Drugs		
Other Service	Audiology Services		
Other Service	Dental Services		
Other Service	Environmental Accessibility Adaptations and Architectural Modification		
Other Service	Family Counseling		
Other Service	Family Training		
Other Service	Nutrition Services		
Other Service	Occupational Therapy		
Other Service	Physical Therapy		
Other Service	Physician Services (provided by a Psychiatrist)		
Other Service	Psychological Services		
Other Service	Self Directed Goods and Services (SD-GS)		
Other Service	Specialized Medical Supplies and Assistive Technology		
Other Service	Speech Therapy		
Other Service	Transportation 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):**

Adult Day Services

**HCBS Taxonomy:**

**Category 1:**

|

**Sub-Category 1:**

**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):**

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

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

Services are normally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week. This service must be authorized in the member's plan of care.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Adult Day Care Centers

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Adult Day Services**

**Provider Category:**

Agency

**Provider Type:**

Adult Day Care Centers

**Provider Qualifications**

**License (specify):**

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

**Certificate (specify):**

**Other Standard (specify):**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Oklahoma State Department of Health

Oklahoma Health Care Authority

**Frequency of Verification:**

Oklahoma State Department of Health - Annually

Oklahoma Health Care Authority - Ongoing

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Habilitation

**Alternate Service Title (if any):**

Habilitation Training Specialist Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**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):**

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

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

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

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

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

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

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

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Habilitation Training Specialist Services**

**Provider Category:**

Agency

**Provider Type:**

Habilitation Training Specialist Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

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

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OKDHS/DDSD

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Habilitation Training Specialist Services**

**Provider Category:**

Individual

**Provider Type:**

Habilitation Training Specialist

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

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

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OKDHS/DDSD

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Homemaker

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**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 consisting of general household activities such as meal preparation and routine household care provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemaker services can help a member with activities of daily living when needed. Agency Homemaker providers are supervised by provider agency staff with a minimum of four years of any combination of college level education and/or full time equivalent experience in serving people with disabilities. Individual Homemaker providers are supervised by OKDHS/DDSD residential program staff.

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

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

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

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Homemaker
Agency	Homemaker Agency

## Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Individual Homemaker

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

OKDHS/DDSD

Frequency of Verification:

Annually

## Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Homemaker Agency

Provider Qualifications

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OKDHS/DDSD

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Prevocational Services

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**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*):

These are services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to members not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

When compensated, members are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the member's Individual Plan (Plan) as directed to habilitative, rather than explicit employment objectives. Documentation will be maintained in the file of each member receiving this service that: The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

Each provider agency assesses each member in maximizing employment options. Assessments are updated and reviewed annually in the member's Team, as described in Appendix D-1:c, process. It is the responsibility of each provider to ensure services are provided in the most integrated setting appropriate to meet the member's needs.

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

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Workshops and Other Prevocational Agencies

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Prevocational Services**

**Provider Category:**

Agency

**Provider Type:**

Workshops and Other Prevocational Agencies

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

Current SoonerCare Provider Agreement with OHCA to provide employment services to OKDHS/DDSD waiver members.

Prevocational service providers must:

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OKDHS/DDSD

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**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 provided to members unable to care for themselves and furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite care is provided in the following locations: member's home or place of residence or approved community site, group home, Agency Companion home, Specialized Foster Care home or Medicaid certified ICF-ID.

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

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

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

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

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

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

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Group Homes

**Provider Qualifications**

**License (specify):**

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

**Certificate (specify):**

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

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

Training requirements per OAC 340:100-3-38

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

OKDHS/DDSD

**Frequency of Verification:**

Annually

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Agency Companion

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

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

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

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

OKDHS/DDSD

**Frequency of Verification:**

Annually

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Medicaid-Certified ICF-ID

**Provider Qualifications****License** (*specify*):

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

**Certificate** (*specify*):

Medicaid certification by the Oklahoma Health Care Authority

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Oklahoma Health Care Authority

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Respite Care Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OKDHS/DDSD

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Individual

**Provider Type:**

Specialized Foster Care Homes

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

OKDHS/DDSD certification

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

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

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

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

OKDHS/DDSD

**Frequency of Verification:**

Background checks verified annually

Training verified bi-annually, at minimum

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**Statutory Service **Service:**Supported Employment **Alternate Service Title (if any):**

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**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):**

Supported employment is conducted in a variety of settings, particularly work sites, in which persons without disabilities are employed. Supported employment includes activities that are outcome based and needed to sustain paid work by members, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by members as a result of their disability, and will not include payment for the supervisory activities rendered as a normal part of the business setting. Supported employment consists of job development, assessment, supportive assistance and job coaching up to 100% of on-site intervention. Stabilization or ongoing support is available for those requiring less than 20% on-site intervention.

Stabilization and extended services are ongoing supported employment services services needed to support and maintain a member with severe disabilities in an integrated competitive employment site. The service includes regular contacts with the member to determine needs, as well as to offer encouragement and advice. These services are provided when the job coach intervention time required at the job site is 20% or less of the member's total work hours. This service is provided to members who need ongoing intermittent support to maintain employment. Typically this is provided at the work site. Stabilization must identify the supports needed in the member's Individual Plan (Plan) and specify in a measurable manner, the services to be provided to meet the need.

Supported employment services furnished under the waiver are not available under a program funded by the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each member receiving this service that the service is not otherwise available under a program funded through the Rehabilitation Act of 1973, or P.L. 94-142. FFP will not be claimed for incentive payments, subsidies or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
- Payments that are passed through to users of supported employment programs; or
- Payments for vocational training not directly related to a member's supported employment program.

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

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Employment Services

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

**Service Type: Statutory Service**

**Service Name: Supported Employment**

---

**Provider Category:**Agency **Provider Type:**

Employment Services

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

Current SoonerCare Provider Agreement with OHCA to provide Employment Services to OKDHS/DDSD HCBS waiver members.

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

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

OKDHS/DDSD

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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**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:****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):**

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

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

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

For members who have not yet reached their 21st birthday, the provisions of EPSDT apply.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Pharmacy

**Appendix C: Participant Services**

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

**Service Type: Extended State Plan Service**

**Service Name: Prescribed Drugs**

**Provider Category:**

Agency

**Provider Type:**

Pharmacy

**Provider Qualifications**

**License (specify):**

Oklahoma State Board of Pharmacy

**Certificate (specify):**

**Other Standard (specify):**

Current SoonerCare Provider Agreement for Pharmacy with the Oklahoma Health Care Authority.

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

Oklahoma Health Care Authority

**Frequency of Verification:**

Annually

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

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

**Service Type:**Other Service 

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

**Service Title:**

Audiology Services

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****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):**

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

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

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

For members who have not yet reached their 21st birthday, the provisions of EPSDT apply.

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

- Participant-directed as specified in Appendix E**

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Audiologist

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Audiology Services

**Provider Category:**

Individual

**Provider Type:**

Audiologist

**Provider Qualifications**

**License (specify):**

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

**Certificate (specify):**

**Other Standard (specify):**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Oklahoma Health Care Authority

**Frequency of Verification:**

Ongoing through the claims process

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Dental Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**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):**

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

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

Coverage of dental services is specified in the member's Plan and may not exceed \$1,000 per plan of care year. If the member needs additional dental services, the Case Manager assists them to identify personal or community resources to meet the needs.

Service members age 18-20 receive dental services through SoonerCare, EPSDT.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Dentist

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Dental Services**

**Provider Category:**

Individual

**Provider Type:**

Dentist

**Provider Qualifications**

**License** *(specify):*

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

**Certificate** *(specify):*

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

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Oklahoma Health Care Authority

**Frequency of Verification:**

Ongoing through the claims process

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Environmental Accessibility Adaptations and Architectural Modification

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

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

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

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

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

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

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Building Contractor

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Environmental Accessibility Adaptations and Architectural Modification****Provider Category:**Individual **Provider Type:**

Building Contractor

**Provider Qualifications****License (specify):**

**Certificate (specify):**

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

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Oklahoma Department of Central Services and OKDHS/DDSD

**Frequency of Verification:**

Ongoing through the authorization process

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Family Counseling

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**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):**

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

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

Individual counseling cannot exceed 400, 15-minute units per plan of care year. Group counseling cannot exceed 225, 30-minute units per plan of care year. Case Managers assist the member to identify other alternatives to meet identified needs above the limit.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Psychologist
Individual	Licensed Professional Counselor
Individual	Clinical Social Worker

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

Psychologist

**Provider Qualifications****License (specify):**

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

**Certificate (specify):**

**Other Standard (specify):**

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

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

Oklahoma Health Care Authority

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Family Counseling**

**Provider Category:**

Individual

**Provider Type:**

Licensed Professional Counselor

**Provider Qualifications**

**License (specify):**

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

**Certificate (specify):**

**Other Standard (specify):**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Oklahoma Health Care Authority

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Family Counseling**

**Provider Category:**

Individual

**Provider Type:**

Clinical Social Worker

**Provider Qualifications**

**License (specify):**

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

**Certificate (specify):**

**Other Standard (specify):**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Oklahoma Health Care Authority

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Family Training

**HCBS Taxonomy:**

**Category 1:**

|

**Sub-Category 1:**

|

**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):**

Family Training services include instruction in skills and knowledge pertaining to the support and assistance of members. Services are intended to allow families to become more proficient in meeting the needs of members; provided in any community setting; provided in either group or individual formats; for members served through an OKDHS/DDSD HCBS waiver and their families. For the purpose of this service, family is defined as any person who lives with or provides care to a member served on the waiver; included in the member's Individual Plan (Plan) and arranged through the member's Case Manager; and intended to yield outcomes as defined in the member's Plan.

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

The cost of Family Training services may not exceed \$5500.00 per the member's plan of care year for individual Family Training services and \$5500.00 per the member's plan of care year for Family Training group services. Members may be authorized for Family Training services on an individual basis, as part of a group or they may receive a combination of group and individual training services. The total cost of both individual Family Training and group Family Training may not exceed \$11,000.00 per the member's plan of care year. The Case Manager assists the member to identify other alternatives to meet identified needs above the limit.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

Provider Specifications:

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

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Family Training**

**Provider Category:**

Individual

**Provider Type:**

Qualified Individual

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

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

Current licensure, certification or Bachelors Degree in a human service field related to OKDHS/DDSD approved curriculum.

OKDHS/DDSD Family Training application and training curriculum approved by OKDHS/DDSD.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OKDHS/DDSD

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Family Training**

**Provider Category:**

Agency

**Provider Type:**

Family Training Agency or Business

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

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

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

OKDHS/DDSD Family Training provider application and training curriculum approved by OKDHS/DDSD.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OKDHS/DDSD

**Frequency of Verification:**

Ongoing

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

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

**Service Title:**

Nutrition Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**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):**

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

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

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

The OKDHS/DDSD Case Manager assists the member to identify other alternatives to meet needs above the limit.

For Waiver members who have not yet reached their 21st birthday, these services are provided through SoonerCare, EPSDT.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Dietitian/Nutritionist

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

**Service Type: Other Service**  
**Service Name: Nutrition Services**

**Provider Category:**

Individual

**Provider Type:**

Dietitian/Nutritionist

**Provider Qualifications****License (specify):**

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

**Certificate (specify):**

Certification as a Dietitian with the Commission on Dietetic Registration

**Other Standard (specify):**

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

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

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

Oklahoma Health Care Authority

**Frequency of Verification:**

Ongoing through the claims process

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

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

**Service Type:**Other Service 

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

**Service Title:**

Occupational Therapy

**HCBS Taxonomy:****Category 1:**

|

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

Occupational therapy includes the evaluation, treatment and consultation in leisure management, daily living skills, sensory motor, perceptual motor and mealtime assistance. Services are intended to contribute to the member's ability to reside and participate in the community. Services are rendered in any community setting as specified in the member's Plan. The member's Plan must include a Physician or Advanced Practice Nurse prescription.

These services are provided through the waiver to adults. Therapy services are provided to children through SoonerCare, EPSDT. Assessment services for the purpose of home or vehicle modification may be provided through the waiver for adults and children.

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

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

The OKDHS/DDSD Case Manager assists the member to identify other alternatives to meet needs above the limit.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Occupational Therapist

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Occupational Therapy**

**Provider Category:**

Individual

**Provider Type:**

Occupational Therapist

**Provider Qualifications**

**License** (*specify*):

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

**Certificate** (*specify*):

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

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Oklahoma Health Care Authority

**Frequency of Verification:**

Ongoing through the claims process

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Physical Therapy

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****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):**

Physical Therapy Services include the evaluation, treatment and consultation in locomotion or mobility and skeletal and muscular conditioning, and maximize the member's mobility and skeletal/muscular well-being. Services are provided in any community setting as specified in the member's Plan. The Plan must include a Physician's prescription.

These services are provided through the waiver to adults. Therapy services are provided to children through SoonerCare, EPSDT. Assessment services for the purpose of home or vehicle modification may be provided through the waiver for adults and children.

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

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

The OKDHS/DDSD Case Manager assists the member to identify other alternatives to meet needs above the limit.

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

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

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

- Legally Responsible Person**
- Relative**

Legal Guardian**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Physical Therapist

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

Physical Therapist

**Provider Qualifications****License (specify):**

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

**Certificate (specify):**

**Other Standard (specify):**

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

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

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

Oklahoma Health Care Authority

**Frequency of Verification:**

Ongoing through the claims process

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

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

**Service Type:**Other Service 

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

**Service Title:**

Physician Services (provided by a Psychiatrist)

**HCBS Taxonomy:****Category 1:****Sub-Category 1:**

**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):**

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

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

For Waiver members who have not yet reached their 21st birthday, the provisions of SoonerCare, EPSDT apply.

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

The OKDHS/DDSD Case Manager assists the member to identify other alternatives to meet needs above the limit.

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

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

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

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

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Psychiatrist

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Physician Services (provided by a Psychiatrist)**

**Provider Category:**

Individual **Provider Type:**

Psychiatrist

**Provider Qualifications****License** (*specify*):

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

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

D.O.-Oklahoma Statute Supplement'98, Section 620 et seq.

**Certificate** (*specify*):

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

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

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

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

Oklahoma Health Care Authority

**Frequency of Verification:**

Ongoing through the claims process

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

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

**Service Type:**

Other Service

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

**Service Title:**

Psychological Services

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****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*):

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

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

For Waiver members who have not yet reached their 21st birthday, the provisions of SoonerCare, EPSDT apply.

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

The OKDHS/DDSD Case Manager assists the member to identify other alternatives to meet needs above the limit.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Psychologist

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Psychological Services

**Provider Category:**

Individual

**Provider Type:**

Psychologist

**Provider Qualifications**

**License** (*specify*):

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

**Certificate** (*specify*):

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

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

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

Oklahoma Health Care Authority

**Frequency of Verification:**

Ongoing through claims process

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

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

**Service Type:**

Other Service

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

**Service Title:**

Self Directed Goods and Services (SD-GS)

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****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):**

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

- The item or service is designed to meet the member's functional, social or medical needs, advance the desired outcome of the Self Directed Services Support Plan and is included in the member's plan of care.
- The item or service is justified by a recommendation from a licensed professional and is approved on the plan

of care.

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

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

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

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

**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	Typical vendor in the community according to goods and services needed

## Appendix C: Participant Services

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

**Service Type: Other Service**

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

**Provider Category:**

Individual

**Provider Type:**

Typical vendor in the community according to goods and services needed

**Provider Qualifications**

**License** (*specify*):

Not required

**Certificate** (*specify*):

Not required

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

Services, supports and goods can be purchased from typical vendors in the community.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Member/Confirmed by Financial Management Service reporting agent.

**Frequency of Verification:**

Upon purchase and annually at planning meeting

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Specialized Medical Supplies and Assistive Technology

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**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):**

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

Supplies include the following:

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

Specialized Medical Supplies are provided through the waiver to adults. Specialized Medical Supplies are

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

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

Assistive Technology services include:

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

Equipment provided includes:

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

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

Specialized Medical Supplies and Assistive Technology are provided through the waiver to adults. Specialized Medical Supplies and Assistive Technology are available to service members age 18-20 years through the waiver above and beyond that which is covered by the Medicaid State Plan or EPSDT. Specialized medical supplies available to service members age 18-20 years include incontinence supplies and nutritional supplements in certain cases.

For Waiver members in need of assistive technology who have not yet reached their 21st birthday, the provisions of EPSDT apply.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

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

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Medical Supplies and Assistive Technology****Provider Category:**Individual **Provider Type:**

Durable Medical Equipment and/or Medical Supplies Dealer

**Provider Qualifications****License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

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

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

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

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

Oklahoma Health Care Authority

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Medical Supplies and Assistive Technology****Provider Category:**Agency **Provider Type:**

Durable Medical Equipment and/or Medical Supplies Dealer

**Provider Qualifications****License (specify):**

**Certificate (specify):**

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

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

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Oklahoma Health Care Authority

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Speech Therapy

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**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):**

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

These services are provided through the waiver to adults. For members who have not yet reached their 21st birthday, the provisions of SoonerCare, EPSDT apply.

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

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

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Speech/Language Pathologists

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Speech Therapy****Provider Category:**Individual **Provider Type:**

Speech/Language Pathologists

**Provider Qualifications****License (specify):**

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

**Certificate (specify):**

**Other Standard (specify):**

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

Current SoonerCare General Provider Agreement - Special Provisions for Speech/Language Pathologists, with Oklahoma Health Care Authority

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

Oklahoma Health Care Authority

**Frequency of Verification:**

Annually

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

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

**Service Type:**Other Service 

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

**Service Title:**

Transportation Services

**HCBS Taxonomy:****Category 1:****Sub-Category 1:****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 offered in order to promote inclusion in the community, access to programs and services and participation in activities to enhance community living skills specified in the plan of care, and includes transportation to services not SoonerCare reimbursable. Transportation services under the waiver are offered in accordance with the member's Plan. Whenever possible, family, neighbors, friends or community agencies, which can provide this service without charge, will be utilized. Transportation services include adapted, non-adapted and public transportation.

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

Adapted or non-adapted transportation is limited to 14,400 miles per 12 months except in extenuating situations when person-centered planning identifies specific needs that require additional transportation for a limited period. Public transportation is limited to \$5,000 per 12 months. Case Managers assist members to ensure their needs are met in the Team, as described in Appendix D-1:c, planning process. Alternatives such as ride-sharing and utilization of other community supports can be used to ensure needs are met. Additional services can be planned and provided in extenuating circumstances.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Transportation Agencies
Individual	Individual

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Transportation Services**

**Provider Category:**

Agency

**Provider Type:**

Transportation Agencies

**Provider Qualifications**

**License** (specify):

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

**Certificate** (specify):

**Other Standard** (specify):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OKDHS/DDSD

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Transportation Services**

**Provider Category:**

Individual

**Provider Type:**

Individual

**Provider Qualifications**

**License** (specify):

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

**Certificate** (*specify*):

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OKDHS/DDSD

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

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

**Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

**As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

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

**As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

**As an administrative activity.** *Complete item C-1-c.*

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

The OKDHS/DDSD, the operating agency for this Waiver, performs case management functions on behalf of waiver members.

## Appendix C: Participant Services

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

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

**No. Criminal history and/or background investigations are not required.**

**Yes. Criminal history and/or background investigations are required.**

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

(a) A criminal history record search is required by statute and policy prior to an offer to employ a community services worker. (Title 56 OS Sec. 1025.1 et seq.: OAC 340:100-3-39). Any potential employee or volunteer who is not a licensed health professional, including supervisory, management or administrative positions, if the applicant is to provide, on a full time or part time basis, supportive assistance, health related services or training

to a person(s) with developmental disabilities or mental retardation. (b) Each provider requests a statewide criminal records check from the Oklahoma State Bureau of Investigation (OSBI). (c) DDS Quality Assurance Unit annually reviews a sample of the records of each provider to assure that the required documentation is on file for all applicable employees.

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

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

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

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

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

(a) The abuse registry is maintained by the OKDHS. (b) Any potential employee or volunteer who is not a licensed health professional, including supervisory, management or administrative positions, if the applicant is to provide, on a full time or part time basis, supportive assistance, health-related services or training to a person (s) with developmental disabilities or mental retardation, must receive a community services registry check as required by statute and policy prior to an offer to employ. (Title 56 OS Sec. 1025.1 et seq.: OAC 340:100-3-39). Section 1025.1 et seq. or Title 56 of the Oklahoma Statutes requires Oklahoma Department of Human Services (OKDHS) to establish and maintain a registry listing the names of community services workers against whom a final investigative finding of maltreatment involving a member, has been made by OKDHS or an administrative law judge. Requirements contained in statute and in administrative regulations apply to all community services providers who contract with, or are licensed or funded by OKDHS or who contract with Oklahoma Health Care Authority (OHCA) to provide residential or employment services to members through OKDHS/DDS HCBS waivers. Community services workers include persons who have entered into Agreements with OHCA to provide specialized foster care, habilitation training specialist services, or homemaker services to persons with developmental disabilities as well as persons employed by or under contract with a community services provider to provide HCBS waiver services. Licensed health professional are regulated by their respective licensing boards and are not subject to inclusion on the community services worker registry. (c) Provider agencies are required to conduct the pre-employment registry check. Quality Assurance Unit annually reviews a sample of the records of each provider to assure that the required documentation is on file for all applicable employees. OKDHS is the investigative authority for allegations of maltreatment involving vulnerable adults. In addition to sending investigation reports to the appropriate District Attorney, reports in which a confirmation of maltreatment (as defined in state statute) is made against a licensed health professional are sent to the licensed professional's respective licensure Board.

## 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).**

## 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.*

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.**

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

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

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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

Relatives/legal guardians who are legally responsible for the member are prohibited from being paid as direct contract providers of waiver services except when they are the only available provider of covered services due to geographical remoteness or they are uniquely qualified to provide such services due to considerations such as language. Any non-legally responsible relative/legal guardian who serves as paid provider must be qualified to provide the service and meet licensure/certification requirements. The term non-legally responsible relative includes a mother and father of an adult, brother, sister or child including those of in-law and step relationship.

Provider agencies may hire non-legally responsible relatives/legal guardians to provide waiver services when the relative/legal guardian is qualified to provide the service. Provider agencies must provide supervision and oversight of employees and ensure that claims are submitted only for services rendered. Members participating in self direction provide supervision and oversight of employees and ensure that claims are submitted only for

services rendered. The Financial Management Service subagent ensures that claims are submitted only for services authorized in the self directed plan of care.

Services relatives/legal guardians may provide include: Audiology, Dental, Respite, Homemaker, Habilitation Training Specialist, Nutrition, Occupational Therapy, Physical Therapy, Physician (Psychiatrist), Speech Therapy, Transportation, Prevocational, Supported Employment and Self Directed Habilitation Training Specialist services.

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

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

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

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

- Other policy.**

Specify:

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

Through OHCA's website, providers have ready access to information requirements and procedures to qualify, and the timeframes established for qualifying and enrolling in the program. OHCA provides for continuous, open enrollment of waiver service providers. To participate in SoonerCare, providers must have an agreement on file with the OHCA. The OHCA Provider Enrollment Unit is responsible for validating that any provider meets all of the requirements of participation. The rules applicable to these provisions are found at 317:30-2 and 317:10-1-19. Providers interested in becoming a SoonerCare provider may request a SoonerCare enrollment packet by downloading the required forms, contacting Provider Enrollment by phone, or sending a request in writing by mail to OHCA. OKDHS/DDSD staff assists potential providers by providing applications, and technical assistance, reviewing information to assure the provider qualifications are met and submitting them to OHCA for processing. Once a provider agreement is approved, the agreement remains in effect until the expiration date indicated on the agreement. In the absence of a "Notice of Termination" by either party, the agreement is renewed every three years as cited in the renewal section of the contract. Whenever a change of ownership occurs, a new provider agreement must be signed. After reviewing the application, certification criteria, and verifying appropriate licensure, certification, etc., OHCA assigns a 10-digit provider number to the new provider. Providers receive written notification of their provider number and the agreement certification effective and expiration date. The provider also receives a PIN letter informing the provider of their PIN to access the OHCA secure website. Hewlett-Packard (HP), the MMIS support vendor, mails out a welcome packet and contacts the provider within ten working days to offer training. Renewal notices are sent to each provider 75 days prior to the expiration date of their

contract. A reminder is sent 45 days prior for those that have not been updated. If the renewal is not returned to OHCA, no payments for dates of service after the agreement expiration date are made.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

As a distinct component of the 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**

**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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

**Performance Measure:**

**Number and percent of new provider applications, by provider type, (denominator) for which the provider obtained appropriate licensure/certificate in accordance with state law and waiver provider qualifications prior to service provision (numerator).**

**Data Source** (Select one):

**Program logs**

If 'Other' is selected, specify:

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

	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	

**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):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

Number and percent of providers, by provider type, (denominator) continuing to meet applicable licensure/certification following initial enrollment (numerator).

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Oklahoma Board of Medical Licensure and Supervision**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	

		<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of direct support agency providers (denominator) whose direct support staff had timely criminal background checks (numerator).**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

**Provider performance monitoring (2300)**

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

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>

**Performance Measure:**

Number and percent of direct support agency providers (denominator) whose direct support staff had timely registry checks (numerator).

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

**Provider performance monitoring (2301)**

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 provider applicants (denominator), by provider type, who met initial waiver provider qualifications (numerator).**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Provider applications**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

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

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

**Provider performance monitoring (2328)(4121)(4301)(5141)**

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

**Performance Measure:**

**Number and percent of direct support agency providers (denominator) meeting individual specific training requirements (training identified to address the member's specific needs)(numerator).**

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

**Provider performance monitoring (2308)**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and percent of direct support agency providers (denominator) meeting basic training requirements (Foundation training, effective teaching course, First Aid, CPR and medication administration training, if medications are administered) (numerator).

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

**Provider performance monitoring (2307)**

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

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of direct support agency providers (denominator) meeting job specific training requirements (general courses designed to meet the needs of the job) (numerator).**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

**Provider performance monitoring (2309)**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b>

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of direct support agency providers (denominator) meeting annual training requirements (12 hours of the required re-certification classes in First Aid, CPR and medication administration training, if medications are administered) (numerator).**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

**Provider performance monitoring (2315)**

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

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>

**Performance Measure:**

**Number and percent of direct support agency providers (denominator) meeting training requirements for Program Coordinators (numerator).**

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

**Provider performance monitoring (2316)(2317)(2318)(2319)**

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

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**  
 Number and percent of OKDHS/DDSD Case Managers (denominator) that have completed required training as per the Case Management Competency Checklist (numerator).

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

**Operating agency performance monitoring (Area Survey Q9)**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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.  
 Provider agencies who have entered into Agreements with OHCA to provide waiver services are required to correct identified deficiencies within 60 days. OKDHS/DDSD Quality Assurance staff follow-up to ensure completion. Follow-up is documented in provider performance monitoring reports. Any agency which does not correct a deficiency within 60 days is subject to review and sanction by the OKDHS/DDSD Performance Review Committee. OKDHS/DDSD Quality Assurance staff continue to follow-up until deficiencies are corrected. If, after sanctions and follow-up, a provider remains non-compliant, OKDHS/DDSD recommends Agreement termination action to OHCA.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party(check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: <input type="text"/>

**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

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### C-3: Waiver Services Specifications

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

## Appendix C: Participant Services

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### 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.*

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

Individual Support Plan (Plan)

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

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

*Specify qualifications:*

Requirements for an OKDHS/DDSD Case Manager consist of a Bachelor's Degree in a human services field and one year of experience working directly with individuals with developmental disabilities; or possession of a valid permanent Oklahoma license as approved by the Oklahoma Board of Nursing to practice professional nursing and one year working directly with individuals with developmental disabilities.

- Social Worker.**

*Specify qualifications:*

**Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

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

**b. Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

## Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Using the person-centered planning approach, the Plan is developed by the Team, representation in which includes the member, his or her Case Manager and the member's legal guardian and/or the member's choice of an advocate if there is one. Others may be included depending on the member's needs and preferences. The Team is composed of individuals selected by the member who know and work with the member or whose participation is necessary to achieve the outcomes desired by the member. The member and his/her representative are informed of freedom of choice of provider and given assistance if needed in locating a qualified service provider.

## Appendix D: Participant-Centered Planning and Service Delivery

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

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the

service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

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

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

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

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

Prior to the initial and each annual Team, as described in Appendix D-1:c, meeting, the Case Manager consults with the member and the member's advocate or legal guardian, if there is one, to review the individual situation, including the member's desired vision and progress in attaining the vision. At this time, the member and the member's advocate or legal guardian are informed of services available under the waiver and of other sources of services in the community and under the State Plan. In-Home Supports Waiver brochures are provided to members/guardians/representatives during the intake process and a written list of services is provided by the Case Manager upon request. Among the questions explored are whether the member is satisfied with the results of the Plan and whether outcomes need to be revised based on the progress achieved or on changing circumstances in the member's life. This review provides a clear agenda for the Team, as described in Appendix D-1:c, meeting and assures the member's input and participation. The Case Manager consults with the family to schedule a time and place convenient with the member and the family/representative/guardian. Planning for the meeting begins three months (90 days) in advance of the plan of care expiration.

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

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

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

Planning focuses on the needs and outcomes the member wishes to achieve. The Team, as described in Appendix D-

1:c, considers the preferences of the member first and family, friends, and advocates secondarily.

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

- (1) basic demographic information, including emergency information and health and safety concerns;
- (2) assessment information;
- (3) description of services and supports prescribed by the Team, as described in Appendix D-1:c,;
- (4) outcomes to be achieved;
- (5) action steps or methods to achieve the outcomes, including:
  - (A) the means to assess progress;
  - (B) the names of persons or the agency positions responsible for implementing each part of the Plan; and
  - (C) target dates by which each segment of the Plan is to be completed or evaluated for possible revision;
- (6) methods to address health risks and needs;
- (7) community participation strategies and activities;
- (8) identification of all needed staff training, with required time lines for completion, in accordance with OAC 340:100-3-38; and
- (9) medication support plan, as explained in OAC 340:100-5-32.

Team, as described in Appendix D-1:c, members implement responsibilities identified in the Plan or in OKDHS/DDSD or OHCA policy. Implementation of the Plan may only be delegated to persons who are appropriately qualified and trained.

The Case Manager ensures the Team, as described in Appendix D-1:c, makes maximum use of services which are available to all citizens and assures the Team, as described in Appendix D-1:c, identifies all needed services and supports.

The Case Manager assures the services and supports developed by the Team, as described in Appendix D-1:c, support the member's own network of personal resources. The willing efforts of family members or friends to support areas of the member's life are not replaced with paid supports.

Each member served has a single, unified Plan. All services and supports, both waiver and non-waiver, are an integral part of the Plan. The OKDHS/DDSD Case Manager is responsible for coordinating and monitoring services, both waiver and non-waiver. Health care needs are an integral part of the planning process. Programs involving professional and specialized services are jointly developed to assure integration of service outcomes. The Team, as described in Appendix D-1:c, ensures that services and supports: are integrated into the member's daily activities; take advantage of every opportunity for social inclusion; reflect positive approaches aimed at skill enhancement; and make use of the least intrusive and least restrictive options.

Each Team, as described in Appendix D-1:c, member responsible for services identified in the Plan sends a quarterly summary of progress on assigned outcomes and action steps to the member's Case Manager. At the request of the member, or the legal guardian, or if the performance of a Team, as described in Appendix D-1:c, member reveals a course of action which is not in the best interest of the member, which is destructive towards the collaborative process of the Team, as described in Appendix D-1:c, or which violates OKDHS policy or accepted standards of professional practice, the Case Manager notifies that Team, as described in Appendix D-1:c, member by letter that his or her services on the Team, as described in Appendix D-1:c, are no longer required.

The OKDHS/DDSD Case Manager monitors all aspects of the Plan's implementation. The OKDHS/DDSD case management electronic database, Client Contact Manager (CCM), reflects the Case Manager's review of the progress.

The Case Manager routinely asks the member and his or her family, guardian, or advocate about their satisfaction with services and supports, and initiates appropriate action to identify and resolve barriers to consumer satisfaction. The Plan is updated as required by ongoing assessment of progress and needs. It is also updated in anticipation of foreseeable life events.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The Personal Support Team (Team), as described in Appendix D-1:c, identifies potential areas in which the member's safety is at risk including physical, emotional, medical, financial, or legal risks, or risk to community participation; the frequency and degree of potential harm to the member or others; and why, when, where, and how the risk to safety may occur. This includes identification of the member's understanding of the risk and their skills and concepts that impact the risks. Risks are identified through review of assessments, reporting from people who know the member and a section of the member's Individual Plan (Plan) specifically addresses risk. When risks are identified, outcomes addressing risks are developed and included in the member's Plan. Back-up plans to address staffing and housing are developed on an individual basis. The back-up plan identifies who is responsible for ensuring back-up services are available and who is responsible for responding to emergencies. The back-up plan must be reviewed and updated as changes occur or as needed. The back-up plan addresses services and supports needed to prevent or reduce risk. Also, back-up plans include plans for back-up staffing and housing. Case Managers are responsible for ongoing monitoring and oversight of the member's Individual Plan, including back-up plans. Back-up plans are reviewed at least semi-annually and on an as needed basis. Case Managers are required to make revisions and modifications, as appropriate, to the member's Plan to ensure the health and safety of the member.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

At least annually, members are informed of and acknowledge their right to freedom of choice in providers. OKDHS/DDSD Case Managers ensure members have information about qualified waiver providers. The Case Manager identifies available providers and provides available information regarding the provider's performance. They may assist the member in contacting and interviewing potential providers. They also assist members when they wish to change providers. The assistance provided is based on the needs and choices of the member.

## Appendix D: Participant-Centered Planning and Service Delivery

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### 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):

During the eligibility process, an Intake worker develops an initial plan of care in conjunction with the member/family/guardian. This plan includes basic service needs identified by the member/family/guardian. Once eligibility is approved, an OKDHS/DDSD Case Manager is assigned. All addendums to the initial plan of care are submitted by the assigned Case Manager who may determine, through the Team, as described in Appendix D-1:c, process, additional service needs and/or required changes to the plan of care. All initial plans of care (level of care evaluations) are submitted to the OHCA Level of Care Evaluation Unit for review and confirmation of a diagnosis of mental retardation, an IQ score of 75 or below, that the MR diagnosis was made before the member's 18th birthday and that the proposed delivery of services is consistent with the member's level of care need. Once this process has been completed the initial eligibility determination is approved by OHCA. A diagnosis of borderline intellectual functioning would constitute a denial by OHCA. Any errors or service discrepancies are directed to the Case Manager for correction. All waiver plans of care are subject to review and approval by both OKDHS/DDSD (the operating agency) and the Waiver Administration and Development department of the OHCA (the Medicaid agency). OHCA does not review and approve all plans of care (level of care reevaluations) prior to implementation; however, all are subject to the Medicaid Agency's approval. OKDHS/DDSD does review a sampling of member charts which includes the plan of care. Review of a representative sample with 95% confidence interval is conducted on a quarterly basis. Reviewed plans of care are compared to policy guidelines, the functional

assessment, and the narrative written detailing the member's living environment, physical and mental limitations and overall needs. All plans of care are subject to the approval of the Medicaid Agency and are made available by the operating agency upon request. OHCA randomly reviews plans of care through several authorities within the Medicaid Agency, such as Program Integrity and Accountability, Quality Assurance/Improvement and Claims/Coding and Integrity Units. In the event provider billing practices are suspect, all pertinent information is forwarded to the OHCA Program Integrity and Accountability department.

## Appendix D: Participant-Centered Planning and Service Delivery

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

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

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

The OKDHS/DDSD Case Manager, who is an employee of the State, monitors implementation of the member's service plan to determine the plan's effectiveness in meeting the needs of the member, to ensure the member's free choice of providers and to ensure the health and welfare of the member is protected. Case Managers assess services rendered to each member at least quarterly. A face-to-face contact occurs at least twice annually. The annual review process includes a discussion of the needs of the member and confirmation that all identified needs are addressed by waiver, non-waiver, or natural supports. The annual review process includes a discussion of the member's back-up plan, whether it was necessary to implement the back-up plan and if so whether the back-up plan was effective; any necessary changes are made to the back-up plan and included in the member's Individual Plan. Back-up plans address back-up housing plans and back-up staffing arrangements.

The operating agency performance monitoring process is a record review of the OKDHS/DDSD Case Manager record, based on a statistically significant random sample of members receiving supports through the waiver. One quarter of the representative sample is monitored each quarter. This results in a complete representative sample being reviewed each year. The record reviews include a review of service plans to assure: all member needs are addressed and preferences considered, by waiver, non-waiver, or natural supports; they are developed according to

policy and updated/revised as needed ensuring an interim meeting was held within 30 days of identification or notification of the need for change in authorization of waiver services; services are delivered in accordance with the service plan including the type, scope, amount and frequency specified in the service plan; and that members are afforded choice between waiver services and institutional care and between/among waiver services and providers. The record review process includes a discussion of the member's back-up plan, whether it was necessary to implement the back-up plan and if so whether the back-up plan was effective; any necessary charges are made to the back-up plan and included in the member's individual plan. Deficiencies are recorded and reported to OKDHS/DDSD Community Services Unit for correction.

The operating agency performance monitoring process is conducted by the OKDHS/DDSD Quality Assurance Unit. CMS waiver assurances have been identified for monitoring and the record review process provides the evidence of compliance. OKDHS/DDSD Quality Assurance staff reviews are based on CMS waiver assurances. The results of these reviews are recorded on monitoring reports, resulting in the creation of data. Review results are entered into a data base and reported to the respective OKDHS/DDSD Area office for remediation. An annual report and other reports as needed are generated for the Quality Management Committee, of which OHCA is a member. OHCA also has access to all performance monitoring activities via a web based system.

If at any time the Case Manager believes that the member is at risk of harm, the Case Manager takes immediate steps necessary to protect the member. Case Managers also receive periodic progress reports from persons who are designated responsible to implement the member's service plan. If the Case Manager determines that services are not effectively addressing the needs or preferences of the member, the Case Manager reconvenes the member's Personal Support Team (Team), as described in Appendix D-1:c, to make necessary changes. If it is determined the provider is not implementing the Plan as required or the provider does not meet contractual responsibilities or policies, the Case Manager consults with the relevant provider to secure a commitment for necessary service changes within an agreed upon timeframe. If necessary changes are not accomplished within the specified time frame, the OKDHS/DDSD Case Management Supervisor intervenes to secure commitments from the provider for necessary change. If the service deficiency is still not resolved as a result of the intervention, a referral for an Administrative Inquiry by the OKDHS/DDSD Quality Assurance Unit is initiated, which may result in provider sanction.

During Personal Support Team meetings, as described in Appendix D-1:c, the OKDHS/DDSD Case Manager informs members and member representatives of their right to request a Team, as described in Appendix D-1:c, meeting at any time.

**b. Monitoring Safeguards. *Select one:***

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

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

## **Appendix D: Participant-Centered Planning and Service Delivery**

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### **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**  
**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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

**Performance Measure:**

**Number and percent of member's records reviewed (denominator), using tools and checklists developed by OKDHS/DDSD Quality Assurance Unit, who had Individual Plans that were adequate and appropriate to their needs and personal goals as indicated in the assessment(s) (numerator).**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**Operating agency performance monitoring (Area Survey Q3)**

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**  
 Number and percent of member's records reviewed (denominator) who had Individual Plans that included a description of each of the services and supports included in the member's plan of care, including the amount, duration and frequency of service (numerator).

**Data Source (Select one):**  
**Operating agency performance monitoring**  
 If 'Other' is selected, specify:  
**Operating agency performance monitoring (Area Survey Q7b)**

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

	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

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

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percent of member records reviewed (denominator) that had an Individual Plan (Plan) checklist completed by the Case Management Supervisor verifying development of the Plan in accordance with policy and procedure requirements (numerator).**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**Operating agency performance monitoring (Area Survey Q7)**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of member Individual Plans (Plans) reviewed (denominator) that were developed as described in the waiver application: - who participates in the Plan development process; - includes outcomes addressing needs; - Plan development provides for assignment of responsibilities to implement and monitor the Plan (numerator).**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**Operating agency performance monitoring (Area Survey Q7a)**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

**Performance Measure:**

**Number and percent of member's records reviewed (denominator) who had service plans updated/reviewed at least annually or when warranted by changes in the waiver member's needs (numerator).**

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

**Provider performance monitoring (1103)**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input type="checkbox"/> <b>Other</b>	<input checked="" type="checkbox"/> <b>Annually</b>	

Specify: <input type="text"/>		<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

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

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**Operating agency performance monitoring (Area Survey Q1)**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>

<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

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

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**Operating agency performance monitoring (Area Survey Q2)**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

**Performance Measure:**

**Number and percent of member's records reviewed (denominator) who received the type, amount, duration, scope and frequency of the services identified in the Individual Plan (numerator).**

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

**Provider performance monitoring (1102)**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**Operating agency performance monitoring (Area Survey Q5)**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

**Performance Measure:**

**Number and percent of waiver member records reviewed (denominator) with an appropriately completed and signed freedom of choice form that specified choice was offered between institutional care and waiver services (numerator).**

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**Operating agency performance monitoring (Area Survey Q6)**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval =

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	95% <input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

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

**Data Source** (Select one):

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**Operating agency performance monitoring (Area Survey Q8)**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
---	--	--

<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. Reference to "Q" numbers or numbers 1000-5000 in the Data Source field represent the OKDHS/DDSD performance tool identifier.

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

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items. Follow-up on provider performance monitoring is completed by OKDHS/DDSD Quality Assurance staff to ensure 100% correction. Provider performance monitoring follow-up documents are completed to verify correction. OKDHS/DDSD emails results of provider performance monitoring to OHCA. Also, provider performance monitoring reports are posted to a web-based system upon completion. The web-based system may be accessed by OHCA at any time. In addition, OHCA representatives are included in the Quality Management Committee. Provider agencies are required to correct deficiencies within 60 days. Failure to do so results in review by the OKDHS/DDSD Performance Review Committee which may impose additional sanctions such as vendor hold. If, after sanctions and follow-up, a provider remains non-compliant, OKDHS/DDSD recommends Agreement termination action to OHCA.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**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**

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**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

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### E-1: Overview (1 of 13)

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

Once a plan of care is developed for a member, an OKDHS/DDSD Case Manager will offer the options of self direction or traditional waiver services for the portion of the plan of care allocated for Habilitation Training Specialist (HTS) services. A member may have all self-directed services, no provider-managed services or a combination of self-directed and provider managed services. The opportunity to choose self-direction is offered during each annual Team, as described in Appendix D-1:c, meeting. The OKDHS/DDSD Case Manager will provide information regarding options and the member's responsibilities and potential liabilities. Training related to SDS is conducted by OKDHS/DDSD, to include a component related to potential liabilities. In addition, the member receives a manual describing SDS services, responsibilities as well as potential liabilities. Members who choose to participate in the Self Directed Services (SDS) option may self direct the portion allocated for HTS. This amount will be used to establish a budget which will then be developed to specify Self Directed Habilitation Training Specialist (SD-HTS) services and/or Self Directed Goods and Services (SD-GS).

Members who opt for SDS will develop an individualized budget for services which they will self direct. The individualized budget for self direction will be no higher than the cost of meeting needs with HTS, Homemaker, Respite Care, Specialized Medical Supplies and Assistive Technology if traditional services were used. OKDHS/DDSD Case Managers will assist the member to explore options and develop a self directed budget. Each member (or their personal representative) will have both the employment and budget authority over the self directed services.

OKDHS/DDSD will serve as the Financial Management Service (FMS) in a Government Fiscal Employer Agent (FEA) model. OKDHS/DDSD will also operate as an Organized Health Care Delivery System (OHCD) and use a subagent in accordance with Section 3504 of the IRS code and Revenue Procedure 80-4 and Notice 2003-70. Based on the member's Plan and budget, the subagent sets up an individual account, makes payments that follow the authorized budget, handles all payroll functions on behalf of the member who hires service providers and other support personnel, provides the member with a monthly report of expenditures and budget status, answers inquiries, solves related problems, and provides OKDHS/DDSD Case Managers with documentation of expenditures. OKDHS/DDSD has an Interagency Agreement with the State's Medicaid agency.

## Appendix E: Participant Direction of Services

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### 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 participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

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

Once a plan of care is developed for a member, an OKDHS/DDSD Case Manager will offer the options of self direction or traditional waiver services for the portion of the plan of care allocated for Habilitation Training Specialist (HTS) services. This amount will be used to establish a budget which will then be developed to specify Self Directed Habilitation Training Specialist (SD-HTS) services and/or Self Directed Goods and Services (SD-

GS). The OKDHS/DDSD Case Manager will provide information regarding options and the member's responsibilities and potential liabilities. Members who choose to participate in the Self Directed Services (SDS) option may self direct the portion allocated for HTS.

Once a member elects to self direct his/her services and supports, the member or their representative must enroll and complete a 4-6 hour course in self-direction prior to implementation of self directed services. This training addresses:

- staff recruitment;
- hire staff common law employer;
- orient and instruct staff in duties consistent with approved service specifications;
- supervise staff including scheduling of staff and services;
- evaluate staff performance;
- discharge staff (common law employer);
- philosophy and history of self direction;
- OHCA policy governing self direction in Oklahoma;
- individual budgeting including determining staff wages and benefits subject to State limits and the amount paid for services within State limits;
- developing a self directed support plan;
- cultural diversity; and
- rights, risks and responsibilities.

Training also includes an overview of the roles and responsibilities of the OKDHS/DDSD Case Manager, FMS subagent and the member.

The FMS subagent will provide a packet of information and instructions on forms, timesheets, timeframes for completion of forms, payment calculation sheets for the SD-HTS, vendor payment forms, worker compensation information, reporting individual account information and budgeting tips to self-direction participants.

Members may contact the OKDHS/DDSD Case Manager or FMS subagent at any time for problem resolution, technical assistance or guidance.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

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

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

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

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

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

A legal representative or non-legal representative of the member may direct self directed waiver services. Members may appoint a family member, another relative or a friend to direct waiver services on their behalf. If a member is married, his/her spouse may direct the spouse's services, but cannot be paid as a SD-HTS. A legal guardian of a member may self direct services on the member's behalf.

An appointed representative must:

- be 18 years of age or older;
- be approved by the member or legal guardian to act in the capacity of a representative;
- demonstrate knowledge and understanding of the member's needs and preferences;

- comply with self directed services responsibilities and policy;
- sign the Self Directed Services Agreement with the FMS subagent and member in which the appointed representative agrees to assist the member in participating in the program. The agreement includes conditions related to assistance with fiscal management, training requirements, critical incident reporting, etc.; and
- complete the required SDS training.

Safeguards:

- The member or the member's legal representative, OKDHS/DDSD Case Manager and FMS subagent will monitor use of allotted budget to assure only approved services are provided and compensated.
- The FMS subagent will require receipts for all prior authorized purchases in which the members or their representative submit a vendor request form for reimbursement.
- Members choosing to self-direct are included in the random sample for monitoring conducted by OKDHS/DDSD Quality Assurance Unit. Additionally, case management monitoring, including progress report reviews, serve to ensure the best interest of the member.

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

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

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Habilitation Training Specialist Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Self Directed Goods and Services (SD-GS)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

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

- Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- Governmental entities**  
 **Private entities**

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

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

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

- FMS are covered as the waiver service specified in Appendix C1/C3**

**The waiver service entitled:**

- FMS are provided as an administrative activity.**

**Provide the following information**

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

OKDHS/DDSD serves as a Financial Management Service (FMS) in a Government Fiscal Employer Agent (FEA) model and also operates as an Organized Health Care Delivery System (OHCDS) using a subagent. A Request For Proposal (RFP) was initiated by the State for a subagent in order to procure an entity in compliance with general Oklahoma Department of Central Services contracting and purchasing rules and State purchasing law including but not limited to 74 O.S. 85 et. seq. and 74 O.S. 4243. The entity was required to have a minimum of five years experience working with self directed service budgets and payroll. The entity has entered into an Agreement with OKDHS/DDSD to serve as a subagent and has also signed an Agreement with the State's Medicaid agency, Oklahoma Health Care Authority (OHCA), to perform billing transactions on behalf of OKDHS/DDSD. OKDHS/DDSD has an Interagency Agreement with OHCA.

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

Payment was established during the contracting process. The subagent receives an administrative fee. Services are paid as a flat monthly charge per member.

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

---

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

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- Assists participant in verifying support worker citizenship status**  
 **Collects and processes timesheets of support workers**  
 **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**  
 **Other**

*Specify:*

Obtains criminal background check and completes required registry checks.

---

Supports furnished when the participant exercises budget authority:

---

- Maintains a separate account for each participant's participant-directed budget**  
 **Tracks and reports participant funds, disbursements and the balance of participant funds**  
 **Processes and pays invoices for goods and services approved in the service plan**  
 **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**  
 **Other services and supports**

*Specify:*

---

Additional functions/activities:

---

- Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**  
 **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**  
 **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**  
 **Other**

*Specify:*

Executes and holds OHCDSD Provider Agreements as authorized.

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

(a) OKDHS/DDSD reviews reports, invoices or other valid indications of performance to assure all contract terms and conditions of contract with the subagent are met. The subagent is required to be bonded and/or have sufficient liability insurance to protect members and the State against loss of funds, fraud or mismanagement. The subagent is required to provide an annual audit as well as monthly reports. (b) OKDHS/DDSD, Oklahoma Department of Central Services and OHCA. OHCA randomly reviews plans of care through several authorities within the Medicaid Agency, such as Program Integrity and Accountability, Quality Assurance/Improvement and Claims/Coding and Integrity Units. The DDSD Program Manager for self directed services is responsible for actual monitoring of all programmatic aspects of the contract including Consumer Satisfaction Surveys. (c) Monthly and more frequently upon request.

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

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

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

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

The OKDHS/DDSD Case Manager provides the following information and assistance to the member in support of self direction:

- develop the plan of care with the member;
- ensures that services are initiated within required time frames;
- facilitate the development of and review the status of the member's self directed services budget;
- conduct ongoing monitoring of the implementation of the plan of care and member health and welfare;
- arrange alternative emergency back-up services as necessary in the event that the emergency back-up plan provided for in the plan of care cannot be employed;
- specify additional staff qualifications in the Individual Plan (IP) based on member needs and preferences so long as such qualifications are consistent with approved qualifications;
- specify additional service provider qualifications consistent with approved qualifications;
- in the IP, specifies how services are provided, consistent with approved service specifications; and
- refers providers to the Financial Management Service (FMS) subagent for enrollment.

The OKDHS/DDSD Case Manager also may assist in locating and securing services and other community resources that promote community integration, community membership and independence, as provided in the member's plan. The Case Manager will be provided training regarding self direction including their roles and responsibilities in facilitating the development and review of the self directed budget, arranging back-up services and the roles and activities related to self direction.

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Respite	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>
Psychological Services	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Dental Services	<input type="checkbox"/>
Prescribed Drugs	<input type="checkbox"/>
Specialized Medical Supplies and Assistive Technology	<input type="checkbox"/>
Nutrition Services	<input type="checkbox"/>
Physician Services (provided by a Psychiatrist)	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>
Habilitation Training Specialist Services	<input type="checkbox"/>
Transportation Services	<input type="checkbox"/>
Speech Therapy	<input type="checkbox"/>
Audiology Services	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>
Self Directed Goods and Services (SD-GS)	<input type="checkbox"/>
Family Counseling	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Environmental Accessibility Adaptations and Architectural Modification	<input type="checkbox"/>
Family Training	<input type="checkbox"/>
Adult Day Services	<input type="checkbox"/>

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

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

## Appendix E: Participant Direction of Services

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

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

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

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

--

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Members who decide to discontinue directing their services may return to traditional waiver services. Their OKDHS/DDSD Case Manager assists them in returning to traditional waiver services including assistance with free choice of any willing and qualified provider. The OKDHS/DDSD Case Manager will assist in developing a revised plan for traditional waiver services and the funding will follow them back to traditional waiver services. Since the option to self direct is covered under the same waiver, there will be no disruption of services. Members will continue to self direct until traditional waiver services are in place.

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Members may be terminated involuntarily from self direction and offered traditional waiver services under the following circumstances:

- immediate health and safety risks associated with self direction;
- intentional misuse of funds following intensive technical assistance and support from the OKDHS/DDSD Case Manager, FMS and it's subagent;
- fraud; and
- when member or representative continues to violate SDS waiver policies and procedures even after training and technical assistance by OKDHS/DDSD. Some examples would be: not providing receipts with vendor requests forms to the FMS subagent, failure to submit timesheets to the FMS subagent in a timely manner, failure to provide reports to the OKDHS/DDSD Case Manager, failure to report critical incidents or refusal to follow outcome related activities.

When action is taken to terminate the member from self directed services involuntarily, the OKDHS/DDSD Case Manager assists the member in accessing needed and appropriate services through traditional waiver services, ensuring that no lapse in necessary services occurs for which the member is eligible. The Fair Hearing process and notice apply when any action is taken to involuntarily terminate self directed services.

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	56

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 2		64
Year 3		72
Year 4		80
Year 5		88

## Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

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

Specify how the costs of such investigations are compensated:

The cost is paid by the member out of the IHSW-A self directed budget.

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**  
 **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**  
 **Determine staff wages and benefits subject to State limits**  
 **Schedule staff**  
 **Orient and instruct staff in duties**  
 **Supervise staff**

- Evaluate staff performance
- Verify time worked by staff and approve time sheets
- Discharge staff (common law employer)
- Discharge staff from providing services (co-employer)
- Other

Specify:

## Appendix E: Participant Direction of Services

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

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

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the State's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

## Appendix E: Participant Direction of Services

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

**b. Participant - Budget Authority**

**ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The amount of the individual budget is based on the amount authorized in the plan of care for the services the member has elected to direct and cannot exceed the cost limit described in section B-2:a of this application. Each member has a unique individual budget based on the needs of the member as determined by the member and Personal Support Team, as described in Appendix D-1:c. Web site [www.okdhs.org/divisionsoffices/visd/ddsd/default.htm](http://www.okdhs.org/divisionsoffices/visd/ddsd/default.htm) contains policy related to self-directed services to include budget methodology. The web site address is listed in the Helpful Web Sites section of the self-directed services manual provided to members. The OKDHS/DDSD Case Manager assists the member in

updating the budget during the plan of care year as necessary. The member's individualized budget accounts for the actual cost of administrative activities performed by the FMS subagent such as obtaining criminal history and/or background investigations of staff, completion of required registry checks, processing payroll, etc. Individualized budget methodology is described in OHCA policy and available for public viewing via the web at any time.

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The OKDHS/DDSD Case Manager will inform member of the budget amount, in accordance with approved rules, during the annual plan of care meeting. During Team, as described in Appendix D-1:c, meetings OKDHS/DDSD Case Managers inform members and member representatives of their right to request a Team, as described in Appendix D-1:c, meeting which may include a request for an adjustment to the budget/service plan at any time. Members are advised by the OKDHS/DDSD Case Manager of their right to request a Fair Hearing and informed of the procedure for doing so during the planning process.

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- Modifications to the participant directed budget must be preceded by a change in the service plan.**
- The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## Appendix E: Participant Direction of Services

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

#### b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FMS subagent and OKDHS/DDSD Case Manager work with the member to ensure the budget is utilized according to the authorized budget and SDS Support Plan. When problems are identified, the FMS subagent and OKDHS/DDSD Case Manager work together with the member to find solutions and make changes as needed. The FMS subagent sets up an individual account, based on the member's approved budget, makes expenditures that follow the authorized budget, provides the member with a monthly report of expenditures and budget status, and provides the OKDHS/DDSD Case Manager with access to the member's individual account information. The OKDHS/DDSD Case Manager utilizes the information provided to monitor

expenditures. The FMS subagent also provides DDS State Office staff with a monthly report of expenditures. In addition, members are issued a login identification number and password which may be used to view account information via the FMS subagent web site. These methods are used to prevent premature depletion of the individual budget as well as budget underutilization.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The "Documentation of Consumer Choice" form explains the right to a Fair Hearing and provides information regarding the process for requesting a Fair Hearing. The form also includes a section requiring the choice between Home and Community-Based Services (HCBS) under the Waiver and institutional care and acknowledges the freedom of choice of providers. This form is reviewed annually and a copy is maintained in the case file and in Oklahoma Department of Human Services (OKDHS) Central Records. The member and/or his/her representative are informed of all changes in service provision (denial, reduction, suspension or termination of services) through a written notice. These notices are generated automatically by the authorization system or, in the case of denial or termination, by the OKDHS. This notice includes the information regarding the method of requesting a Fair Hearing. In addition, any adverse action relating to SoonerCare eligibility generates a notice from the Information Management System (IMS) which includes information relating to requesting a Fair Hearing. The OKDHS/DDS Case Manager assists the member or their representative in requesting and preparing for a Fair Hearing. The notice specifies that services may continue pending the outcome of the appeal, if requested. The Hearing process and other information regarding this process is explained in OAC 340:2-5 and based on Section 168 of Title 56 of the Oklahoma Statutes and applicable Federal regulations.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- No. This Appendix does not apply**

- Ⓒ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

The OKDHS Office of Client Advocacy (OCA) is responsible for the operation of the grievance system.

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The OKDHS grievance system is a multi-tiered system that affords members the opportunity to have their concerns heard and addressed beginning at the local level and continuing, through an appeals process, to the Director of the OKDHS.

The OKDHS Office of Client Advocacy's (OCA) administrative rules set forth the procedures to be followed as well as the timelines for each stage of the process (OAC 340:2-3-45). Notice of the member's right to file a grievance is provided upon initiation of services and annually thereafter. Timelines for response range from five working days for first level resolution to 15 days for the OKDHS Director's review of an appealed grievance. Each OKDHS/DDSD Area office designates a staff person to serve as the Local Grievance Coordinator (LGC). The LGC assists members at every stage of the process and monitors each grievance filed to ensure timely and adequate response.

Grievances may be filed by any person receiving services from OKDHS/DDSD or by anyone interested in the welfare of a member. The subject matter of the grievance may be about any policy, rule, decision, behavior, action or condition made or permitted by the OKDHS, its employees or other persons authorized to provide care including contract provider agencies and their employees.

OKDHS/DDSD contract provider agencies are required by policy to establish a grievance process that must be approved by OCA. The process must include, at a minimum, notice of the member's right to file a grievance and to a reasonable response, timelines for response, right to appeal and the designation of an LGC who is responsible for implementation of the agency's grievance process. Timelines for response to grievances range from five working days for first level resolution to ten working days for the agency's Board of Directors (or appeals committee designated by the Board).

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

The OCA grievance system in no way undermines the member's right to request a Fair Hearing. OKDHS policy provides that DDSD waiver members are granted Hearings if the application for services is denied; when resources are sufficient for initiation of Home and Community-Based Services (HCBS) waiver services and action is not taken within 45 days; or the member, family, or guardian is aggrieved because of OKDHS actions to suspend, terminate or reduce services. All other complaints or grievances are made to OCA and are addressed in accordance with OCA policies and procedures (OAC 340:2-5-61). OKDHS/DDSD Case Managers assure that members understand that filing a grievance or making a complaint is not a pre-requisite or substitute for a Fair Hearing. OKDHS/DDSD Case Managers provide the information annually to members, their advocates and guardians regarding both processes. They are also available to assist in requesting a Fair Hearing or filing a grievance.

OKDHS/DDSD Quality Assurance staff evaluate all service-related complaints received. The type of complaint is not limited. OKDHS/DDSD Quality Assurance staff establish a reasonable timeframe, not to exceed 60 days for correction, and informs individuals responsible for making or overseeing the necessary corrections of actions needed to facilitate change or correction. These actions may include problem solving or other more extensive oversight or change. The OKDHS/DDSD Quality Assurance Administrator may authorize an Administrative Inquiry (AI) in response to a complaint regarding support services made by members or any interested person (OAC 340-100-3-27.1). This does not affect a member's right to a Fair Hearing; rather, it provides an opportunity to determine if the member's rights are being protected.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (complete Items b through e)
- No. This Appendix does not apply** (do not complete Items b through e)  
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical Incident Reporting Requirements: OKDHS policy directs providers who have entered into Agreements with OHCA to provide waiver services as well as OKDHS/DDSD staff to report critical and non-critical incidents involving the health and welfare of members receiving OKDHS/DDSD In-Home Support Waiver services. Contract provider staff report critical and non-critical incidents electronically via the OKDHS/DDSD Provider Reporting System. The OKDHS/DDSD Case Manager is notified immediately when there is a critical incident. If the incident occurs outside regular working hours, the OKDHS/DDSD Case Manager is notified the next working day. Critical incidents include: 1) suspected maltreatment (abuse, verbal abuse, sexual abuse, neglect, financial neglect, exploitation, or sexual exploitation) of a member; 2) threatened or attempted suicide by a member; 3) death of a member; 4) an unplanned hospital admission of a member; 5) a medication event resulting in emergency medical treatment of a member; 6) law enforcement involvement in a situation concerning a member; 7) property loss of more than \$500.00 involving a member; 8) a member is missing; and 9) a highly restrictive procedure is used with a member. In addition to the immediate notification requirement, the contract provider or OKDHS/DDSD staff who witnessed or has knowledge of the incident completes an Incident Report. Contract provider program coordination staff reviews each Incident Report, describes in writing the action taken in response to the incident, and submits the Incident Report via the electronic reporting system that automatically records the date and identity of the program coordinator submitting the report. The electronic reports of critical incidents are automatically sent to the OKDHS/DDSD Case Manager for review and further action, if necessary, and to the OKDHS/DDSD State Office for review by the Critical Incident Committee.

In addition to the general reporting requirements above, allegations of possible maltreatment are subject to additional reporting requirements. Oklahoma statutes require any person having reasonable cause to believe that a vulnerable adult is suffering from maltreatment to make a report to the OKDHS, the Office of the District Attorney in the county in which the suspected maltreatment occurred or the local municipal Police Department or Sheriff's Department as soon as the person is aware of the situation. For members receiving services through the In-Home Supports Waiver for adults, the investigative authority within OKDHS is the Office of Client Advocacy. Investigative procedures are described in G-1 d. below.

Non-Critical Incident Reporting Requirements: The procedures for reporting incidents considered as "non-critical" are identical to those described for critical incidents except that immediate notification is not required and reports of non-critical incidents are not provided to OKDHS/DDSD State Office. Incident Reports must be submitted to OKDHS/DDSD case management within 72 hours of the incident. Incident Reports are required under the following circumstances: 1) injury occurs to a member; 2) unplanned health-related event; 3) physical aggression by a member; 4) fire setting by a member; 5) deliberate harm to an animal by a member; 6) property loss of less than \$500.00 involving a member; 7) vehicle accident involving a member; 8) suspension, termination or removal of a member's program; and 9) a medication event involving a service recipient. OKDHS/DDSD case management staff are responsible for reviewing each Incident Report and taking further action when necessary. With respect to medication events, the OKDHS/DDSD Case Manager may notify the OKDHS/DDSD RN if the Case Manager

believes the medication error caused harm or if the Case Manager needs technical assistance on appropriate follow-up activities.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The OKDHS/DDSD Case Manager provides information and education along with written materials to the member and his/her legal guardian or advocate, when appropriate, regarding member rights, responsibilities, the grievance process and procedures, pertinent phone number(s) and how to report maltreatment during the meeting held to develop the Needs Assessment and Individual Support Plan. Thereafter, information and materials are available upon request by the member, family and/or legal guardian and routinely provided during annual reevaluation. Case Managers are responsible for ongoing monitoring of the health and welfare of members and providing necessary education and intervention related to the reporting of maltreatment of members. In the event of a change in Case Manager or Case Management Supervisor, new names and phone numbers are provided.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The OKDHS is the entity to which reports are submitted. Within the OKDHS, two divisions are responsible for receipt, evaluation and response to critical incidents depending on the nature of the incident. The divisions responsible are the Office of Client Advocacy (OCA) for incidents of alleged maltreatment of members, and the Developmental Disabilities Services Division (OKDHS/DDSD) for incidents identified in Appendix G-1-a. that do not rise to the level of maltreatment.

The OKDHS maintains a statewide toll free hotline for the purpose of receiving reports of maltreatment of children and adults. The hotline operates 24 hours a day, seven days a week and is staffed by State personnel trained in reporting procedures.

Within the OKDHS, OCA is responsible for evaluating and investigating allegations of maltreatment of adults receiving in-home supports. OCA Intake determines from available information whether the situation presents a serious risk that requires immediate action. If an emergency response appears indicated, OCA arranges for an investigator, a law enforcement officer or an OCA advocate to personally visit with the alleged victim immediately and no later than within 24 hours. Emergency situations are those in which a member is likely to suffer death or serious physical harm without intervention.

OCA administrative rules specify extensive procedures for the conduct of investigations. The OCA investigator conducts an interview with the alleged victim within 5 working days of assignment. A separate, private interview is conducted with each alleged victim, witnesses to the alleged maltreatment, persons allegedly directly or indirectly involved in the allegation, persons with knowledge of relevant information, and each caretaker accused of the maltreatment. All interviews are tape-recorded and interpreter services are provided for persons with hearing impairments.

If the investigator becomes aware of a significant health or safety concern requiring immediate attention, he/she promptly informs appropriate OKDHS/DDSD or Adult Protective Services staff. Other persons or entities are notified as warranted. The investigator remains with the member until safety can be assured.

All cases are assigned within one working day of receipt of a referral. Investigation is commenced immediately upon receipt of a referral deemed urgent. Within 30 calendar days of disposition, the investigative process is completed and appropriate administrators notified. Within 60 calendar days from the assignment of an investigation, the OCA written investigative report is completed. OCA supervisors monitor timely completion of investigation reports and oversee completion of reports that are pending over 30 days.

When the finding does not confirm an allegation or the finding is confirmed but the accused caretaker is not a community services worker, OCA sends a copy of the report to the provider agency administrator, the OKDHS/DDSD Director, and the applicable district attorney. When the finding confirms an allegation against a caretaker who is a community services worker, OCA submits a copy of the report to the applicable District Attorney and processes the report per the due process requirements for inclusion of the caretaker's name on the Community Services Worker Registry. When due process procedures relating to the registry have been completed, OCA sends a copy of the report to the provider agency administrator and the OKDHS/DDSD Director. The provider agency

administrator is responsible for notifying the participant or the participant's legal representative of the OCA finding. The investigative findings are approved within 30 to 60 calendar days of disposition of a referral to be investigated. Investigations resulting in confirmation against a caretaker who is a Community Services Worker are not considered final until the due process procedures relating to the Community Services Worker Registry have been completed. The timeframes for notification of the member or member's legal representative in these cases vary. During executive session of the monthly Commission meeting, the OKDHS Director and members of OKDHS Commission review information regarding confirmed findings and the corresponding disciplinary actions taken.

Critical incidents that do not constitute maltreatment are reviewed and evaluated by OKDHS/DDSD. All deaths, regardless of circumstance, are reported immediately to the OKDHS/DDSD Director or designee. The member's family member(s) or legal guardian is notified by OKDHS/DDSD case management staff or by the respective provider agency. The member's Team, as described in Appendix D-1:c, and HRC review all critical incidents involving the use of an intrusive procedure or emergency intervention, other than medication previously approved per OAC 340:100-5-26.1, to ensure the use was reasonable, necessary, and consistent with the PIP or an emergency intervention, as defined in OAC 340:155-5-57(f). Critical incidents involving the use of intrusive procedures or emergency interventions are reported in writing to OKDHS/DDSD case management and OKDHS/DDSD Positive Field Support staff within 72 hours of the incident, as specified in OAC 340:100-5-57.1. The member's Team, as described in Appendix D-1:c, meets within 5 days of receipt of the written report to review the incident. Case management prepares a monthly summary of all restrictive or intrusive procedures, PRN psychotropic medication usage, or emergency interventions reported. The monthly summary identifies system concerns, recommendations, and planned interventions. The monthly summary is forwarded to the OKDHS/DDSD Director of Psychological and Behavioral supports who reviews and takes any necessary action.

All other critical incidents, as defined in OAC 340:100-3-24(b), are reported immediately to OKDHS/DDSD case management. If the incident occurs outside regular working hours, OKDHS/DDSD on-call staff are notified immediately. Providers who have entered into Agreements with OHCA to provide waiver services submit a written report of all critical incidents to the OKDHS/DDSD Case Manager and OKDHS/DDSD State Office staff within 72 hours after the incident occurs.

- 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 OKDHS is the entity to which reports are submitted. Within the OKDHS, two entities are responsible for receipt, evaluation and response to critical incidents depending on the nature of the incident. The Office of Client Advocacy is responsible for incidents of alleged maltreatment, and OKDHS/DDSD is responsible for incidents identified in Appendix G-1:a that do not rise to the level of maltreatment.

OCA reports their findings related to maltreatment of any In-Home Supports Waiver for Adults (IHSW-A) member to OKDHS/DDSD. Provider agencies are required, by policy, to report critical incidents immediately to OKDHS/DDSD, using the approved format.

Oversight activities are continuous and ongoing. Issues related to maltreatment or member health and safety are first addressed individually for immediate resolution. For critical and non-critical incidents a standardized format is used and data is entered electronically by the HCBS waiver provider agencies and is immediately routed to Case Managers and, in the case of critical incidents, to DDSD State Office staff. On a monthly basis the information is compiled into various reports (e.g. by type of incident, frequency, by member, by provider) and provided to the OKDHS/DDSD Critical Incident Committee for analysis, to identify trends, and make recommendations. The Critical Incident Committee meets monthly after reviewing all critical incidents. Committee activities include a discussion of individual incidents and trends and system recommendations. An annual report is made available to the Quality Management Committee, which includes OHCA representation. Additionally, OHCA has access to all provider monitoring activities via a web based system that can be accessed at any time.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

**The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Individual Planning policies 340:100-5-50 through 100-5-58 focus on individualized, person-centered services and supports promoting positive approaches aimed at skill enhancement and use of the least intrusive/restrictive options. Policy 340:100-1-3.1 states "Supports which address challenging behaviors are positive; use the least restrictive appropriate approach; are designed and implemented with the participation and consent of the individual and guardian; and focus on establishing bonds of companionship, trust, safety, and security between the person and those providing support". Policy 340:100-1-2 defines least restrictive as "Services and supports which maximize the service recipient's independence and freedom and are provided in a manner that is the least restrictive and intrusive possible to meet the service recipient's needs."

The planning process includes assessments identifying the member's support and service needs and choices related to personal relationships, home, employment, education, transportation, health, safety, leisure, social skills, and communication. There is also a focus on early intervention/prevention, assessing and addressing areas in which the member's safety is at risk such as physical, emotional, medical, financial or legal risks or risk to community participation.

When risks are identified, the Individual Plan (Plan) must include protective intervention planning that describes preventive supports, services, and actions to be taken to reduce or eliminate risks. The Protective Intervention Plan (PIP) must treat the member with dignity and be reasonable, humane, practical, not controlling and reflect the least restrictive alternatives. Prior to considering use of highly restrictive procedures for behavioral control, less restrictive alternative procedures are required to be tried and proven ineffective in keeping the member and others safe. These non-restrictive, preventative, pro-social procedures as identified in policy 340:100-5-57, include requirements/changes in the member's environment; program/service requirements including consistency of support staff; frequency/quality of supervision/oversight of support staff; communication between Team, as described in Appendix D-1:c, members; daily activities; an educational plan with teaching methods for learning skills/concepts; detailed instructions for staff interaction with the member/others; and recognition of early signs/clues/other indications of potential safety risk.

If the Team, as described in Appendix D-1:c, determines restrictive/intrusive procedures are essential for safety, the PIP must include sufficient justification for their use and "fading criteria" for the reduction/elimination of the restrictive/intrusive procedure. PIPs which include restrictive/intrusive procedures must be approved and reviewed at least annually by the Human Rights Committee (HRC) and the Statewide Behavior Review Committee (SBRC). Policies 340:100-3-6 and 340:100-3-14 identify the composition, function and record-keeping duties of these committees.

The SBRC reviews each PIP with restrictive/intrusive procedures. SBRC members are appointed by the OKDHS/DDSD Division Administrator and include at least three professional members with expertise in areas relating to the duties of the committee, including positive behavior supports/educational methodologies; member rights; and related medical/psychiatric issues. The committee includes at least two individuals who receive OKDHS/DDSD services or a family member/guardian/advocate of an individual who receives OKDHS/DDSD services. The OKDHS/DDSD Director of Psychological and Behavioral Supports chairs the committee.

The SBRC ensures each PIP complies with policy 340:100-5-57 and focuses on prevention, education, skill development, staff training/conduct, and other positive approaches. When restrictive/intrusive

procedures are requested, the SBRC ensures that due process is afforded, the restrictive/intrusive procedure is the least restrictive alternative, and educational procedures are in place to assist the member in restoring restricted rights. The SBRC is the final approval authority. The SBRC sends a copy of the PIP review to the OKDHS/DDSD Case Manager specifying that the PIP is approved; given time-limited approval with required changes to be made; or not approved with required information/changes to be provided. The OKDHS/DDSD Case Manager convenes the Team, as described in Appendix D-1:c, within ten days of receipt of the review to make necessary changes to the PIP.

PIPs must be modified to address recommendations of the SBRC and approved prior to implementing proposed restrictive/intrusive procedures. SBRC approval is for one year and must be renewed annually as long as the restrictive/intrusive procedure is in place.

In addition to review and approval by the SBRC, the HRC reviews each PIP containing restrictive/intrusive procedures at least annually. HRCs are established and operated by provider agencies. HRC members may not be employed by an agency providing direct services and funded by either the operating agency or the Medicaid agency. At least one HRC member must be an individual receiving services or a family member and one member must be a professional with expertise in areas such as positive behavioral supports, client rights or related medical/psychiatric issues. HRC members are trained using OKDHS/DDSD approved curriculum. The HRC's role is to provide external monitoring/advocacy that is separate and apart from the provision of services and which specifically addresses the protection of individual rights, program conditions, policy/procedure review, and resolution of complaints/concerns related to the protection of individual rights. At least annually, the HRC reviews each PIP containing restrictive/intrusive procedures. At a minimum, HRC meetings include review of PIP's containing rights restrictions and restrictive/intrusive procedures and recommendations, if any; and review of incident reports noting any pattern of frequent use of restrictive/intrusive procedures. Meeting minutes are reviewed by OKDHS/DDSD Quality Assurance Unit staff during provider performance monitoring. If the HRC becomes aware of tuse of a restrictive/intrusive procedure not in accordance with policy 340:100-5-57, the HRC must request an Administrative Inquiry from the OKDHS/DDSD Quality Assurance Unit.

Use of restraint procedures is regulated by policies at 340:100-5-26, 340:100-5-26-1, 340:100-5-51 through 340:100-5-58. Physical management (personal restraint) is used only to prevent physical injury and ensure safety. Seclusion and facedown physical restraint are prohibited. Mechanical restraints are prohibited except when absolutely necessary to promote healing/prevent injury during/following a medical procedure. Medical mechanical restraints are prescribed by a Physician and time-limited to 12 hours unless the Physician allows a longer period. Drugs are used as restraints only in very limited circumstances including the use of PRN medication for behavior control. PRN drugs for behavior management must be ordered by the member's Physician, reviewed by the OKDHS/DDSD Pharmacy Director and included in an approved PIP with a specific protocol for use as well as a plan to reduce use. When PRN medication is used, an incident report must be completed per policy 340:100-5-57.1 and the OKDHS/DDSD Case Manager must convene the Team, as described in Appendix D-1:c, to review the incident.

Use of a restrictive/intrusive procedure not included in a PIP is considered an emergency intervention. Emergency intervention is used only when necessary and no longer than is necessary to eliminate the clear and present danger of serious physical harm to the member or others. Physical management must stop as soon as the person is calm or the threat has ended and release must be attempted every two minutes. The amount of force can never exceed that which is reasonable and necessary under the circumstances to protect the member or others. An incident report must be completed and submitted to the OKDHS/DDSD Case Manager for Team review within five working days.

Staff must complete an approved physical management course before using any physical management technique identified in a PIP. Only staff and their supervisors who provide support to the member are trained. Staff who have been formally trained to use physical management procedures do not use those techniques with other members receiving services, except in emergencies as defined in 340:100-5-57. Provider staff must complete an annual retraining on restrictive physical management procedures in the PIP.

After use of an emergency restraint procedure, the OKDHS/DDSD Case Manager reviews the Incident Report and ensures the Team, as described in Appendix D-1:c, meets within five days of the emergency

intervention. If the Team, as described in Appendix D-1:c, determines that the use of a restraint procedure must continue to ensure the safety of the member/others, the DDS Director of Psychological and Behavioral Supports or designee may provide temporary approval to continue use. Approval lasts no longer than 45 days. The request must provide sufficient documentation that positive supports were attempted, and the danger of severe harm still exists. Required information includes all incident reports from the last three months with details on the harm caused and other indications of severity, as well as a description of existing positive supports/services. To continue using the temporarily approved procedure, the Team, as described in Appendix D-1:c, must submit a PIP that includes the requested procedures. If the PIP does not receive SBRC approval, but conditions warrant an extension, the SBRC may extend the temporary approval for 45 additional days.

Policy 340:100-3-34 requires that the provider notify the member's guardian or family member when an incident occurs. Policy 340:100-5-57.1 states that the member's Team, as described in Appendix D-1:c, and HRC review any use of an intrusive procedure, other than medication previously approved per policy 340:100-5-26.1, or an emergency intervention to ensure the use was reasonable, necessary, and consistent with the PIP or in accordance with policy 340:100-5-57. In addition, policy 340:100-5-57.1 states an incident report is required when an intrusive procedure or emergency intervention is used. The OKDHS/DDS Case Manager reviews the report and ensures the member's Team, as described in Appendix D-1:c, meets within five days of receipt of an incident report documenting use of an intrusive procedure or emergency intervention to ensure the use was reasonable and the least restrictive alternative available. The DDS Director of Psychological and Behavioral Supports and the Positive Support Field Specialist (PSFS) also review the incident reports and take further action as needed to ensure policy requirements are followed. Such action may include assigning the PSFS to provide assistance; requesting an Administrative Inquiry per policy 340:100-3-27.1; suspending approval for use of physical management or emergency intervention if there has been a violation of policy requirements pending review by the SBRC per policy 340:100-3-14; notifying the authorities if it appears abuse or neglect has occurred; and requiring additional staff training or supports.

- 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:

DDS oversight activities relating to restraints are ongoing.

When a restraint procedure is used, other than medication previously approved in accordance with OAC 340:100-5-26.1, an Incident Report form is prepared by the person of the provider agency who initiated the procedure in accordance with OAC 340:100-5-57.1. The Incident Report includes, at a minimum, a description of: the circumstances leading to the use of the intrusive procedure(s) or emergency intervention(s), including all procedures attempted prior to using the intrusive procedure or emergency intervention; the intrusive procedure or emergency intervention procedure(s) used; and the outcome of the incident, including any physical harm or damage caused.

Provider agency program coordination staff review the Incident Report and complete a written review which indicates whether: the intrusive procedure(s) was implemented according to the PIP or the emergency intervention(s); the intervention complied with the requirements of subsection (f) of OAC 340:100-5057; the use of intrusive procedure(s) or emergency intervention was reasonable and necessary; and includes recommendations and a description of actions taken. Provider agency program coordination staff send a copy of Critical Incident Reports and review to the member's HRC and the OKDHS/DDS Case Manager as well as OKDHS/DDS State Office immediately following the incident.

The OKDHS/DDS Case Manager ensures the Team, as described in Appendix D-1:c, meets within five days of receipt of the Incident Report documenting use of physical management or emergency intervention. The Team, as described in Appendix D-1:c, reviews the particulars of the incident to insure use was reasonable and the least restrictive alternative available. The Team, as described in Appendix D-1:c, takes necessary action to address any identified issues, describes any systems concerns, addresses any further recommendations, and/or planned interventions.

A data base captures information related to the use of restrictive/intrusive procedures by member served, agency providing services, location of intervention, and time of use. The OKDHS/DDS Director of Psychological and Behavioral Supports and the

Positive Support Field Specialist review Incident Reports including highly restrictive procedures on a monthly basis.

- If it appears that use of restrictive or intrusive procedures or emergency intervention has occurred in violation of policy requirements, approval for use of physical management or emergency intervention may be suspended by the OKDHS/DDSD Director of Psychological and Behavioral Supports pending review by the Statewide Behavior Review Committee (SBRC) in accordance with OAC 340:100-3-14.
- If it appears that abuse or neglect has occurred, the authorities charged by law with the investigation of alleged abuse are notified.
- The OKDHS/DDSD Director of Psychological and Behavioral Supports may require additional staff training or supports.
- The Positive Support Field Specialist may be assigned to provide assistance to the Team, as described in Appendix D-1:c.
- If problems are noted, an Administrative Inquiry in accordance with OAC 340:100-3-27.1 may be requested.

In addition to review by the OKDHS/DDSD Director of Psychological and Behavioral Supports, a Critical Incident Committee reviews all critical incidents, including but not limited to, those involving the use of restraint procedures. The Committee meets regularly to review reports generated from a data base containing data collected from Incident Reports. The Committee is charged with analyzing the reports to identify systems issues, trends, and patterns and makes findings and recommendations to support continuous quality improvement and prevent recurrence. Reports of the Committee's findings and recommendations are provided to the Quality Management Committee for review. The Quality Management Committee includes a representative from the Oklahoma Health Care Authority (OHCA).

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

#### b. Use of Restrictive Interventions. *(Select one):*

- The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- The use of restrictive interventions is permitted during the course of the delivery of waiver services**  
Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restrictive procedures are defined in OKDHS policy as those which result in the limitation of the member's rights including their communication with others, access to leisure activities, money or personal property, goods or services, movement at home or the community or any direct observational procedures specified as a result of challenging behavior during times or places which would otherwise be considered private. Use of restrictive procedures is regulated by OAC 340:100-5-50 through 340:100-5-58. Aversive conditioning procedures, withholding meals, breaks, sleep or the ability to maintain personal hygiene, involuntary forfeiture of money or personal property, corporal punishment and the use of exclusionary time out or time out rooms are all prohibited.

Individual Planning policies include a foundation for planning individual, person-centered services and supports which foster positive approaches aimed at skill enhancement and make use of the least intrusive and least restrictive options. The planning process includes individual assessments that identify the member's needs and choices for supports and services related to personal relationships,

home, employment, education, transportation, health, safety, leisure, social skills, and communication. There is also a focus on early intervention and prevention by the Team, as described in Appendix D-1:c, when changes occur and assessing and addressing areas in which the member's safety is at risk including physical, emotional, medical, financial, or legal risks or risks to community participation.

The member's Plan must include protective intervention planning which describes preventive supports, services, and actions to be taken to reduce or eliminate risks. This includes, as needed, identifying requirements or changes in the member's environment, program and service requirements, instruction and procedures to be taken by staff or Team, as described in Appendix D-1:c, members during a situation that places the safety of the member or others at risk, education components, staff training requirements, and methods and timelines to evaluate the effectiveness of the member's Plan. The PIP must treat the member with dignity and be reasonable, humane, practical, not controlling and the least restrictive alternative. If the Team, as described in Appendix D-1:c, determines that restrictive procedures are essential for safety, the protective intervention planning must include sufficient justification for their use. The PIP must be approved and reviewed at least annually by the HRC and the SBRC. Policies relating to the composition, function and record-keeping of these committees are found at OAC 340:100-3-6 and 340:100-3-14.

OKDHS/DDSD Case Managers, who facilitate Team, as described in Appendix D-1:c, meetings, complete required training courses and in-services including training on rights issues, use of restrictive procedures and the process for approval of restrictive procedures (Foundation Training, Individual Plan Training, Mentoring Manual). Direct support staff responsible for the day-to-day implementation of restrictive procedures and their supervisors, complete training which includes Foundation Training and individual-specific in-service on the PIP. Residential staff also complete a Residential Ethical and Legal training course.

Policy found at OAC 340:100-3-38 states "Staff must complete annual retraining on physical management or physical restraint procedures in the approved protective intervention plan." In addition, policy at OAC 340:100-3-38 states that the member's Team, as described in Appendix D-1:c, specifies required time frames for completion of individual-specific in-service training. The procedures in a member's protective intervention plan are considered individual-specific training for staff. If time frames are not identified in the Individual Plan, required individual-specific in-service training must be completed before working with the member.

As the member's needs require changes in supports or programs, the Team, as described in Appendix D-1:c, documents in the Individual Plan, or in addenda to the Plan, any new or additional in-service training required, with time frames for completion. Policy 340:100-5-57.1, regarding Reporting and Monitoring the Use of Restrictive or Intrusive Procedures or Emergency Interventions, states that the DDSD Director of Psychological and Behavioral Support may require additional staff training after review of incident reports involving use of intrusive procedures or emergency interventions.

Incident reporting policy at OAC 340:100-3-34 requires contract provider staff and OKDHS/DDSD staff to report injuries and behavioral or health related incidents. An incident report must be submitted. Protective intervention plan development requires identification of specific data collection procedures related to both the pro-social, non-restrictive aspects of the protective intervention plan as well as any restrictive components in the plan. Data collection methods are individualized based on the needs of the plan and staff receive instruction on the data collection procedures as part of the in-service on the protective intervention plan. Typical data collection sheets require documentation each time a technique is used, to include the date of use, time of use, frequency and duration of use as well as whether use of the technique was successful. On a monthly basis, the provider agency program coordination staff sends completed data collection sheets to the case manager or identified team, as described in Appendix D-1:c, professional, such as a psychologist or family trainer, so the data can be analyzed to determine if the plan is being carried out as required, if progress is being made, or if revisions to the plan are needed. In addition, policy 340:100-5-57.1 regarding Reporting and Monitoring the Use of Restrictive or Intrusive Procedures or Emergency Interventions, states that Form 06MP046E, Incident Report, is completed by the provider when an intrusive procedure or emergency intervention is used. Use of p.r.n.(as needed) medications for behavioral control and physical holds are considered highly restrictive procedures and are classified as critical incidents. Incident reporting policy 340:100-3-34 states that contract provider staff notifies the DDSD Case Manager immediately when there is a critical incident. If the incident occurs outside regular working hours, DDSD on-call staff is

notified immediately. When contract provider staff notifies emergency on-call staff, the DDS case manager must be notified within one working day of the incident. Contract provider staff then submits the critical incident report, to the DDS Case Manager and DDS State Office within 72 hours after the incident.

The SBRC is established to review each PIP with restrictive procedures. The OKDHS/DDS Division Administrator appoints SBRC members. The SBRC includes at least three professional members with expertise in areas relating to the duties of the committee, including: positive behavior supports and educational methodologies; issues involving client rights; and related medical or psychiatric issues. Other members include at least two individuals who receive OKDHS/DDS services or are a family member, guardian, or advocate of an individual who receives OKDHS/DDS services. The OKDHS/DDS Director of Psychological and Behavioral Supports chairs the committee.

The SBRC ensures that each PIP complies with requirements found in OAC 340:100-5-57 and that the PIP focuses on: prevention; education; skill development; staff training and conduct; and other positive approaches. Whenever restraint procedures are requested, the SBRC ensures: that due process is afforded; the restrictive or intrusive procedure is the least restrictive alternative; and that educational procedures are in place to assist the individual in restoring the restricted right(s).

The SBRC is the final approval authority for PIP's that include a restrictive or intrusive procedure (s). The SBRC sends a copy of the PIP review summary to the OKDHS/DDS Case Manager. The review summary specifies whether the PIP is:

- approved;
- conditionally approved, with required information or changes to be provided within a time period specified by the SBRC;
- conditionally approved with required educational supports or staff training as specified; or
- not approved, with required information or changes to be provided within a time period specified by the SBRC. The OKDHS/DDS Case Manager convenes the Team, as described in Appendix D-1:c, within ten days of receipt of the SBRC minutes and summary for review and necessary modifications to the PIP.

PIP's must be modified to accommodate the recommendations of the SBRC and approved prior to implementing the proposed restrictive or intrusive procedure(s). Statewide Behavior Review Committee approval is for no longer than one year and must be renewed annually as long as the restrictive or intrusive procedure is in place.

In addition to review and approval by the SBRC, the HRC reviews each PIP containing a restrictive or intrusive procedure(s), at least annually. Human Rights Committees are established and operated by provider agencies. Members of the HRC may not be employed by an agency providing services to people with developmental disabilities and funded by either the operating agency or the Medicaid agency. At least one member must be an individual receiving services or a family member and one member must be a professional with expertise in areas relating to the duties of the committee such as positive behavioral supports, issues involving client rights or related medical or psychiatric issues. HRC members are trained using OKDHS/DDS approved curriculum. The HRC's role and function is to provide external monitoring and advocacy that is separate and apart from the provision of services and which specifically addresses the issues of protection of individual rights, program conditions, policy and procedure review, and resolution of complaints or concerns related to the protection of individual rights. The HRC reviews, at least annually, each PIP containing a restrictive or intrusive procedure (s). The minutes of each HRC meeting include, at a minimum, the: identification of any PIPs containing rights restrictions or restrictive or intrusive procedures that were reviewed and recommendations, if any; and notation if a pattern of frequent use of restrictive or intrusive procedures or frequent injury is emerging from the HRC's review of incident reports. If the HRC becomes aware of the use of a restrictive or intrusive procedure(s) that is not in accordance with OAC 340:100-5-57, the HRC must request an Administrative Inquiry from the OKDHS/DDS Quality Assurance Unit.

OKDHS/DDS Case Managers monitor the provision of services, including restrictive procedures, semi-annually through observation, record review and provider incident and progress reports.

The DDS Director of Psychological and Behavioral Supports and the Positive Support Field Specialists review incident reports involving the use of restrictive procedures on a monthly

basis. OKDHS/DDSD State Office maintains a data base that captures information by individual served, agency providing services, location of intervention and time the restrictive/intrusive procedure was used.

Upon review of incident reports, the OKDHS/DDSD Director of Psychological and Behavioral Supports and the Positive Support Field Specialist take further action(s) as needed to ensure that requirements governing the use of restrictive/intrusive procedures are followed.

- The Positive Support Field Specialist may be assigned to provide assistance to the Team, as described in Appendix D-1:c.
- If problems are noted, an Administrative Inquiry in accordance with OAC 340:100-3-27.1 may be requested.
- If it appears that abuse or neglect has occurred, the authorities charged by law with the investigation of alleged abuse are notified.
- The OKDHS/DDSD Director of Psychological and Behavioral Supports may require additional staff training or supports.

Data base information, as described in G-2-b, ii, is analyzed to identify trends and/or patterns related to increased use of restrictive/intrusive procedures. Identified trends and/or patterns of usage will be addressed via specified improvement strategies, which may include additional training, monitoring, or oversight.

**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:

Oklahoma Department of Human Services Developmental Disabilities Services Division is responsible for the oversight and monitoring of the use of restrictive interventions and for ensuring that safeguards are followed as noted in c.i. and in accordance with OAC 340:100-5-57.1.

In addition to review by the OKDHS/DDSD Director of Psychological and Behavioral Supports, a Critical Incident Committee reviews critical incidents and other quality management reports, including but not limited to those involving the use of restrictive or intrusive procedures. The Committee meets monthly to review reports generated from a database containing data collected from individual incident reports. The Committee is charged with analyzing reports to identify systems issues, trends, and patterns and will make findings and recommendations to support continuous quality improvement and prevent recurrence. Reports of the Committee's findings and recommendations will be provided to the Quality Management Committee which includes a representative from OHCA. Based on Critical Incident Committee report findings, the Quality Management Committee may make recommendations for policy changes, procedural changes, additional training or monitoring requirements. The Quality Management Committee meets quarterly.

Data collection, as part of each Protective Intervention Plan, assists in identifying unauthorized or inappropriate use of restrictive interventions. Other formal and informal sources of information include any daily staff notes in the residence or at the work site as well as conversations with staff regarding implementation of programs and direct observations of program implementation. Use of Form 06MP046E, Incident Report, is the most used method for detecting unauthorized or inappropriate use of restrictive interventions. Policy 340:100-5-57.1 regarding Reporting and Monitoring the Use of Restrictive or Intrusive Procedures or Emergency Interventions, states that Form 06MP046E, Incident Report, is completed by the provider when an intrusive procedure or emergency intervention is used. Use of p.r.n.(as needed) medications for behavioral control and physical holds are considered highly restrictive procedures and are classified as critical incidents. Incident reporting policy 340:100-3-34 states that contract provider staff notifies the DDS Case Manager immediately when there is a critical incident. If the incident occurs outside regular working hours, DDS on-call staff is notified immediately. When contract provider staff notifies emergency on-call staff, the DDS case manager must be notified within one working day of the incident. Contract provider staff then submits the critical incident report, to the DDS Case Manager and DDS State Office within 72 hours after the incident. If the unauthorized or inappropriate intervention use rises to the level of possible abuse or mistreatment, a referral to the abuse hotline is made. Other unauthorized or inappropriate uses of restrictive interventions can result in a request for staff to be retrained. The contract provider agency administration may also take disciplinary action or remove the staff person(s) from the residence or work site, as appropriate to the situation.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

- The 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.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

## Appendix G: Participant Safeguards

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

#### c. Medication Administration by Waiver Providers

**Answers provided in G-3-a indicate you do not need to complete this section**

##### i. Provider Administration of Medications. *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- 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).

##### 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:

- 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.

## 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, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.*

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 unexplained, suspicious and untimely deaths (denominator) for which review/investigation did not result in the identification of preventable causes (numerator).**

**Data Source** (Select one):

**Mortality reviews**

If 'Other' is selected, specify:

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

	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

Number and percent of member's records reviewed (denominator) where the member (and/or family or legal guardian) received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver (numerator).

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**Operating agency performance monitoring (Area Survey Q12)**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach(check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	

Specify: <input type="text"/>		<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

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

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

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

		Confidence Interval = 95%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number and percent of member's records reviewed (representative sample w/95% confidence) where case management intervention was required (denominator) and occurred to address issues related to incident reports and health and welfare risks if necessary (numerator).

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**Operating agency performance monitoring (Area Survey Q10)**

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number and percent of member's records reviewed (representative sample w/95% confidence) where the provider was required (denominator) and acted immediately to remedy any situation which posed a risk to the health, well-being, safety or provision of specified service (numerator).

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

**Provider performance monitoring (1517)**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.  
Reference to "Q" numbers or numbers in the 1000-5000 series in the Data Source field represent the OKDHS/DDSD performance tool identifier.

Operating agency performance monitoring is based on a proportionate sample.

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

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
Follow-up on provider performance monitoring is completed by OKDHS/DDSD Quality Assurance staff to ensure 100% correction. Provider performance monitoring follow-up documents are completed to verify correction. Provider agencies are required to correct deficiencies within 60 days. Failure to do so results in review by the OKDHS/DDSD Performance Review Committee which may impose additional sanctions such as vendor hold. If, after sanctions and follow-up, a provider remains non-compliant, OKDHS/DDSD recommends Agreement termination action to OHCA.

**ii. Remediation Data Aggregation**

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

Responsible Party(check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**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)

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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 QMS 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 QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

## Appendix H: Quality Improvement Strategy (2 of 2)

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### H-1: Systems Improvement

#### a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

OHCA strives to operate the waiver systematically incorporating the principles of continuous quality improvement. The Long Term Care Quality Initiatives Council (LTCQIC) collaborates for the trending, prioritizing and implementation of system improvement in OHCA waivers. The Council consists of various divisions within OHCA as well as provider agencies, advocacy groups and other stakeholders. The Council meets quarterly to discuss member and provider issues and to set priorities for system-wide quality improvement. The Council receives information from a variety of reports prepared by Waiver Administration as well as provider agencies. As a result of an analysis of the discovery and remediation information presented to the council, system improvements are identified and design changes are made. Waiver reporting for the LTCQIC is stratified by the respective program. The Research Analyst and Senior Program Manager work with the Waiver Administration Director to ensure that data is reported accurately. Both member and provider data are compiled in accordance with the program as noted in the OHCA MMIS.

The LTCQIC annually reviews the Quality Oversight Plan and utilizes numerous quality indicators that are tracked and reported on an annual basis. The State aggregates, verifies, and analyzes the results of the discovery processes to evaluate the indicators for each sub-assurance. The State identifies trends, best practices, and areas for improvement. The LTCQIC develops recommendations for improvement strategies.

Participants in the council represent a wide variety of stakeholders including but not limited to; Waiver Administration staff; Care Management staff, Quality Assurance staff, Legal, Systems, OKDHS, and representatives of Member advocacy groups, and provider agency representatives.

**ii. System Improvement Activities**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Quality Improvement Committee</b>	<input checked="" type="checkbox"/> <b>Annually</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**b. System Design Changes**

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

The Oklahoma Quality Improvement Strategy weaves together various quality assurance and quality improvement activities using a three-tiered process. Tier 1 includes quality assurance processes that are implemented at the member/Case Manager/provider level. Tier 2 includes discovery and remediation processes implemented at the OKDHS/DDSD Program Manager/OHCA Level of Care Evaluation Unit/DDSD Quality Assurance Unit level. Tier 3 is the DDSD State Office Division level and OHCA Medicaid Agency level and focuses on quality improvement at a systems level.

**TIER 1:** The first tier involves strategies to ensure members, advocates, guardians, teams, Case Managers and providers have the tools to develop, implement and monitor quality services. At this level, quality assurance and improvement happens with members on an ongoing basis and is designed to safeguard members.

**TIER 2:** The second tier involves DDSD Program Managers, the OHCA Level of Care Evaluation Unit and the DDSD Quality Assurance Unit as well as committees established to collect and analyze data and make program adjustments to improve service quality. At this level, the strategy is designed to collect and review data from Case Managers, providers, guardians, advocates, members and Teams, as described in Appendix D -1:c, on wide variety of quality indicators and develop remediation and program improvement strategies to

ensure that performance standards and assurances are met.

TIER 3: The third tier involves DDS State Office Executive staff, Office of Client Advocacy and OHCA staff. A Quality Management Committee reviews findings and activities from Tier 2. The committee develops strategies for system improvement, establishes priorities, compiles and communicates Quality Management reports and evaluates and revises the Quality Improvement Strategy annually.

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

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

The Performance Survey is an annual monitoring site visit in which all provider agencies participate, providing data based on an aggregated statistically significant sample of members receiving waiver services and an aggregated statistically significant sample of provider agency staff. The Performance Survey includes all waivers for which the provider agency contracts. Monitoring of service plan development and implementation includes: a review of provider agency records for a random sample of waiver members; and home visits and interviews with waiver members and other pertinent people, for those sampled. The annual monitoring of non-licensed/non-certified provider staff includes a review of personnel records for a sampling of staff assigned to provide supports, to ensure all required employment background checks have been obtained and all required training has taken place. The Performance Survey process provides for a sampling of financial records to ensure compliance with provider Agreements. OKDHS/DDS policy provides the expectation that all identified barriers to performance consistent with the expectation of regulatory policy and contracts are resolved no later than 60 days following the completion of the annual Performance Survey. Failure to correct identified barriers could result in administrative sanctions. The results of Performance Surveys are shared with OHCA and the Quality Management Committee. The data is reviewed to identify trends and areas for improvement. Recommendations are developed for systemic improvement. The Quality Management Committee meets to look at trends and data. Performance measures are developed or updated as needed. The State reviews results, tests new performance measures, analyzes and makes modifications as appropriate.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Representatives from OHCA, OKDHS/DDS and Office of Client Advocacy, participate in a Quality Management Committee. The committee reviews data gathered as a result of the Quality Improvement Strategy and looks for trends. The committee then identifies and prioritizes areas needing improvement. Program staff respond to committee recommendations by designing and implementing improvements. Continued monitoring of performance measures identifies effectiveness of improvements.

At least annually, the Quality Management Committee evaluates the Quality Improvement Strategy and revises if 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).

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

The OKDHS Office of Inspector General (OKDHS/OIG) is the Division within the Oklahoma Department of Human Services charged with the responsibility to investigate allegations of fraud, waste or abuse as well as other allegations of criminal activity against the Department or programs administered by the Department. OKDHS/OIG also has the responsibility to audit vendors and suppliers of Department goods and services under the Federal Single Audit Act of 1984, as well as Divisions and Units of the OKDHS for program compliance and performance. Compliance with the Single Audit Act of 1984 is ensured by the review of independent audit reports for the subrecipients of federal funds. A listing is maintained of audits required. Deficiencies requiring revision by the independent auditor and corrective action plans needed for subrecipients are monitored and resolved.

OKDHS requires all non-licensed and group home providers who receive payments of \$50,000 or more per year to submit a certified independent audit of its operations conducted in accordance with Government Auditing Standards. These audits are required annually and are due 120 days from the provider's fiscal year end. The financial statements are to be prepared in accordance with Generally Accepted Accounting Principles and the report includes a Supplementary Schedule of Awards listing all State and Federal funds by contract Agreement. OKDHS/DDSD staff review these audits and follow-up on any findings relative to waiver programs. In addition, service providers participate in provider performance monitoring at least once each year by the OKDHS/DDSD Quality Assurance Unit, who review documentation related to service delivery to confirm billed charges on a random sample.

All plans of care are subject to the approval of OHCA, the Medicaid Agency, and are made available by OKDHS/DDSD, the operating agency, upon request. OHCA randomly reviews plans of care through several authorities within the Medicaid Agency, such as Program Integrity and Accountability, Quality Assurance/Improvement and Claims/Coding and Integrity Units. OHCA performs a financial audit of the waiver service providers as part of a more comprehensive provider audit process. The financial audit reviews claims in comparison with documentation of services delivery and in comparison with service plan authorization. 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. OHCA Program Integrity and Accountability department is responsible for conducting financial audits on an annual basis.

Errors in provider claims may include (1) claims payment without corresponding documentation of service delivery and (2) claims payment in excess of service plan authorization. Claims error occurrence will be measured for each member and in summary of all members reviewed. Measures of claims error occurrence are (1) percent of units paid without service delivery documentation in the period and (2) percent of units paid in excess of authorized units in the period.

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

## **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.*

##### **i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*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 reviewed claims (denominator) paid in accordance with waiver reimbursement methodology (numerator).**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MMIS/DSS Query, Provider Audits**

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of reviewed waiver claims submitted for Federal Financial Participation (FFP) (demoninator) that are specified in the member's service plan (numerator).**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

**Provider performance monitoring (2201)**

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

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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

**Performance Measure:**

Number and percent of the reviewed member's records (denominator) for whom an entry on DTRK (operating agency electronic tracking system) was made that had a corresponding contact note in Client Contact Manager (CCM) documenting the provision of case management service during the month for each of the last two dates (numerator).

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

**Operating agency performance monitoring (Area Survey Q11a)**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 100%;" type="text"/>

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of payment errors (denominator) remediated in accordance with OHCA policy following error identification through independent provider financial audits (numerator).**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Provider Audits File Review, MMIS Claims Data**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MMIS Claims Data**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Comparison of claims with enrollment file**

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

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):

**Performance Measure:**

**Number and percent of members (denominator) who had a valid level of care on the date of service delivery (numerator).**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.  
 Reference to "Q" number or numbers in the 1000-5000 series in the Data Source field represent the OKDHS/DDSD performance tool identifier.

Operating agency performance monitoring is based on a proportionate representative sample.

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

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
 Follow-up on operating agency performance monitoring is completed by OKDHS/DDSD program staff quarterly to ensure 100% correction of identified problems. Program staff maintain documents to verify correction.

Follow-up on provider performance monitoring is completed by OKDHS/DDSD Quality Assurance Unit staff to ensure 100% correction. Follow-up survey documents are completed to verify correction. Provider agencies are required to correct deficiencies within 60 days. Failure to do so results in review by the OKDHS/DDSD Performance Review Committee which may impose additional sanctions such as vendor hold.

OHCA identifies individual problems during provider audits and in responding to member complaints filed through the Member Inquiry System. Setting quality improvement priorities and development of specific strategies to address quality issues are informed not only by internal discovery and monitoring; but, in addition, by interaction and recommendations from the LTCQIC. Providers identified for remediation must meet performance standards of the Conditions of Provider Participation in order to remain waiver providers. Providers who are under corrective action are given a time period in which improvements must be accomplished. These providers are monitored to ensure they achieve full compliance with standards. Ultimately, OHCA provider agreements can be terminated for failure to meet contractual standards. If, after sanctions and follow-up, a provider remains non-compliant, OKDHS/DDSD recommends Agreement termination action to OHCA.

- ii. **Remediation Data Aggregation**

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input type="checkbox"/>	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**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

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

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

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

**MEDICAID RATE (TXIX)** - 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. Services utilizing the Medicaid Rate are:

- » Specialized Medical Supplies and Assistive Technology\*\*
- » Audiology
- » Dental
- » Family Counseling
- » Nutrition
- » Prescription Drugs

**FIXED RATE** - Title 74 of the Oklahoma Statutes provides a methodology for setting fixed and uniform rates as follows:

- a. Determination of need for a fixed and uniform rate
  - i. New: A new service is developed, or
  - ii. Existing Service: Feedback from providers, clients, or the general public indicates that the existing rate is not sufficient to ensure access to an existing service.
- b. Preparation of a Rates and Standards Brief:

- i. Preparation: Staff prepares a position paper that at a minimum includes a description of the service, the payment history including rates and utilization, the methodology utilized to arrive at the proposed rate, and a description of the funding source.
  - ii. Public Hearing: A public hearing notice is prepared and a hearing is scheduled.
  - iii. Oklahoma Office of Central Services: Copies of the public hearing notice, the Rates and Standards Brief and any other pertinent data is delivered to the Oklahoma Office of Central Services at least 30 days before the date of the public hearing. The Director of the Department of Central Services shall communicate any observation, reservation, criticism or recommendation to the agency, either in person at the time of the hearing or in writing delivered to the State agency before or at the time of the hearing.
- c. Public Hearing Notice: Notice of public hearing will be provided in the following:
- i. Posted in the office of the Secretary of State
  - ii. Posted by the Oklahoma Health Care Authority at its physical location and on the web site calendar.
  - iii. Published by the Oklahoma Health Care authority in various Newspaper publications across Oklahoma.
- d. Public Hearing:
- i. Committee: The public hearing is conducted by the Rates and Standards Committee of the Oklahoma Health Care Authority. The committee is comprised of staff from the OHCA and OKDHS.
  - ii. Public comment: All attendees of the public hearing are offered an opportunity to voice their opposition or approval of the proposed rates. All comments become part of the permanent minutes of the hearing.
- e. Final Approval: The rate is then scheduled for consideration and approval by the Board of Directors of the OHCA prior to implementation.

Services utilizing the Fixed Rate are:

- » Adult Day
- » Habilitation Training Specialist
- » Homemaker
- » Occupational Therapy
- » Physician Services (provided by a Psychiatrist)
- » Physical Therapy
- » Prevocational
- » Psychological
- » Respite Care
- » Speech Therapy
- » Supported Employment
- » Transportation

MANUAL RATE - Services utilizing the Manual Rate and the method and entity responsible for establishing the provider payment rate are:

- » Family Training - Reimbursement made based on rate approved by OKDHS/DDSD after evaluation of provider proposal and rate comparison process, not to exceed limits established at OAC 317:30-5-412.
- » Specialized Medical Supplies and Assistive Technology\*\* - Reimbursement made using current OHCA pricing methodology.

» Environmental Accessibility Adaptations and Architectural Modification - Reimbursement made through a contractor bid process in accordance with Oklahoma State Law.

\*\* Specialized Medical Supplies and Assistive Technology rates are determined using the Manual Rate or may also be determined using the Medicaid Rate if the item is typically covered by Medicaid. If Medicaid State Plan limits associated with the item have been exceeded, but the item is essential to the member's health and/or safety, the item may be authorized through the waiver.

Notice of Authorization statements are automatically issued to waiver members, via an electronic authorization system, upon any change in authorization, to include a rate change.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims for waiver services are submitted by providers directly to and are processed by Oklahoma's CMS-certified Medicaid Management Information System (MMIS) and are subject to all validation procedures included in the MMIS. All claims for waiver services must be matched to an active prior authorization. Prior authorizations are created from the waiver member's individual plan of care.

All claims processed through the MMIS are subject to post-payment validation including, but not limited to SURS. When problems with service validation are identified on a post-payment review, erroneous or invalidated claims are voided from the claims payment system and the previous payment are recouped from the provider.

## 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 review service delivery in comparison with claims and service plan authorization. If the provider audit detects a pattern of inappropriate billing, a referral is made to OHCA Program Integrity and Accountability for review and further investigation of the provider's billing practices.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

**d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

#### g. Additional Payment Arrangements

##### i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

##### ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) OKDHS/DDSD is considered a qualified OHCDS as the agency directly provides Targeted Case Management services utilizing its own employees. (b) Providers will be given the opportunity to enter into a SoonerCare Provider Agreement when they don't voluntarily agree to contract with a designated OHCDS. (c) Members who choose to self direct may choose any qualified provider that has contracted with the OHCDS or has entered into an agreement with OHCA, the State's Medicaid agency. (d) The member who chooses the self direction option and the FMS subagent will assure that all criminal background checks are completed on all prospective Habilitation Training Specialists and that all mandatory training requirements have been met. The member and the FMS subagent will be responsible to maintain copies of the documentation in the employee's file as required by OKDHS/DDSD and OHCA. (e) OKDHS/DDSD will function as the OHCDS and enter into a contract agreement with OHCA. (f) The FMS subagent will be required to be bonded and/or have sufficient liability insurance to protect members and the State against loss of funds, fraud or mismanagement. The FMS subagent is required to provide an annual audit as well as monthly reports.

##### iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of**

**the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**  
 **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

State share funding for services provided under all of Oklahoma's Home and Community-Based Services (HCBS) Waiver programs is from general fund appropriations from the State Legislature made to two State agencies. The Oklahoma Department of Human Services (OKDHS) is responsible for providing State share funding for all waiver services except prescription drugs in excess of State Plan coverage limits and receives Legislative appropriations to cover the same. The Oklahoma Health Care Authority (OHCA) is responsible for providing State share funding for prescription drugs covered under the various waivers and receives Legislative appropriations to cover the same.

On a weekly basis, the OHCA submits a billing to OKDHS for the State share dollars for all waiver services (except prescription drugs) for which provider claims were processed/paid. Through an inter-agency transfer, these State share funds are then deposited into the OHCA's general fund. The transfer of these funds represents a repayment to the OHCA since the OHCA has already paid all provider service claims "in full".

All funding for State share costs of HCBS waiver services in Oklahoma is through Legislative appropriations. There is no funding of State share costs for waiver services using State or local funds from Certified Public Expenditures (CPEs), provider taxes or any other resource.

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

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

## Appendix I: Financial Accountability

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

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

**Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

*Check each that applies:*

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

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

## Appendix I: Financial Accountability

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

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

**None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

**The following source(s) are used**

*Check each that applies:*

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

**No services under this waiver are furnished in residential settings other than the private residence of the individual.**

- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.
- b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings: **Do not complete this item.**

## 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 service recipients are subject to a co-payment on prescription drugs unless the individual service recipient is pregnant or the drug is used for family planning. Co-payments are not applied to other non-pharmaceutical waiver services.

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

#### a. Co-Payment Requirements.

##### iii. Amount of Co-Pay Charges for Waiver Services.

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

Waiver Service	Charge
Prescribed Drugs	<p><b>Amount:</b></p> <p>\$0.00 for preferred generics            \$0.65 for cost of \$0.00-\$10.00            \$1.20 for cost of \$10.01-\$25.00            \$2.40 for cost of \$25.01-\$50.00            \$3.50 for cost of \$50.01 or more</p> <p><b>Basis:</b></p> <p>\$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 payment of \$50.01 or more. Co-payments are for members 21 and older.</p>

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

#### a. Co-Payment Requirements.

##### iv. Cumulative Maximum Charges.

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

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

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

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	16428.07	7206.27	23634.34	69537.37	2186.38	71723.75	48089.41
2	15915.41	7206.27	23121.68	69537.37	2186.38	71723.75	48602.07
3	15840.30	7429.67	23269.97	71693.03	2254.16	73947.19	50677.22
4	15212.36	7429.67	22642.03	71693.03	2254.16	73947.19	51305.16
5	14812.92	7429.67	22242.59	71693.03	2254.16	73947.19	51704.60

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Number Unduplicated Number of Participants (from Item B -3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	1511	1511	
Year 2	1571	1571	
Year 3	1641	1641	
Year 4	1721	1721	
Year 5	1780	1780	

## Appendix J: Cost Neutrality Demonstration

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

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay is based on Form 372 for FY09.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D estimates were made by using current unit rates for years 1 and 2. The current Medical Consumer Price Index (MCPI) for commodities and also the current MCPI for services were averaged to create a combined MCPI of 3.1%. Unit rates for year 3 were increased by 3.1%. Unit rates for years 4 and 5 remained the same as year 3.

Number of users were based on Form 372 for FY09.

Average units per user were based on the total cost for each service, found on Form 372 for FY09.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is based on Form 372 for FY09, then inflated 3.1% at year 3 for the current combined MCPI.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is based on Form 372 for FY09, then inflated 3.1% at year 3 for the current combined MCPI.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is based on Form 372 for FY09, then inflated 3.1% at year 3 for the current combined MCPI.

**Appendix J: Cost Neutrality Demonstration**

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

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
Adult Day Services	
Habilitation Training Specialist Services	
Homemaker	
Prevocational Services	
Respite	
Supported Employment	
Prescribed Drugs	
Audiology Services	
Dental Services	
Environmental Accessibility Adaptations and Architectural Modification	
Family Counseling	
Family Training	
Nutrition Services	
Occupational Therapy	
Physical Therapy	
Physician Services (provided by a Psychiatrist)	
Psychological Services	
Self Directed Goods and Services (SD-GS)	
Specialized Medical Supplies and Assistive Technology	
Speech Therapy	
Transportation Services	

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (5 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Services Total:</b>						<b>677341.44</b>
Adult Day Services	15 min.	81	4448.00	1.88	677341.44	
<b>GRAND TOTAL:</b>						24822813.43
Total Estimated Unduplicated Participants:						1511
Factor D (Divide total by number of participants):						16428.07
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Habilitation Training Specialist Services Total:</b>						17149518.00
Habilitation Training Specialist Services	1 hour	1154	984.00	14.52	16487982.72	
Self Directed	1 hour	49	1103.00	12.24	661535.28	
<b>Homemaker Total:</b>						14661.00
Homemaker	1 hour	3	543.00	9.00	14661.00	
<b>Prevocational Services Total:</b>						2152414.80
Prevocational Services	1 hour	389	1044.00	5.30	2152414.80	
<b>Respite Total:</b>						41903.55
Respite	Per Day	29	19.00	76.05	41903.55	
<b>Supported Employment Total:</b>						2563267.20
Supported Employment	1 hour	282	760.00	11.96	2563267.20	
<b>Prescribed Drugs Total:</b>						116006.40
Prescribed Drugs	1 Rx Each	152	32.00	23.85	116006.40	
<b>Audiology Services Total:</b>						986.58
Audiology Services	Per service	6	3.00	54.81	986.58	
<b>Dental Services Total:</b>						47058.30
Dental Services	Visit	145	6.00	54.09	47058.30	
<b>Environmental Accessibility Adaptations and Architectural Modification Total:</b>						15615.60
Environmental Accessibility Adaptations and Architectural Modification	Per Item	10	6.00	260.26	15615.60	
<b>Family Counseling Total:</b>						15180.75
Family Counseling	15 min.	5	195.00	15.57	15180.75	
<b>Family Training Total:</b>						222422.91
Individual Training	Session	6	45.00	41.39	11175.30	
Group Training					211247.61	
<b>GRAND TOTAL:</b>						24822813.43
Total Estimated Unduplicated Participants:						1511
Factor D (Divide total by number of participants):						16428.07
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Session	21	47.00	214.03		
<b>Nutrition Services Total:</b>						<b>13008.24</b>
Nutrition Services	15 min.	9	56.00	25.81	13008.24	
<b>Occupational Therapy Total:</b>						<b>48480.00</b>
Occupational Therapy	15 min.	24	101.00	20.00	48480.00	
<b>Physical Therapy Total:</b>						<b>120840.00</b>
Physical Therapy	15 min.	57	106.00	20.00	120840.00	
<b>Physician Services (provided by a Psychiatrist) Total:</b>						<b>250.00</b>
Physician Services (provided by a Psychiatrist)	30 min.	1	5.00	50.00	250.00	
<b>Psychological Services Total:</b>						<b>46062.06</b>
Psychological Services	15 min.	22	101.00	20.73	46062.06	
<b>Self Directed Goods and Services (SD-GS) Total:</b>						<b>10279.92</b>
Self Directed Goods and Services (SD-GS)	Per Item	8	7.00	183.57	10279.92	
<b>Specialized Medical Supplies and Assistive Technology Total:</b>						<b>458848.00</b>
Assistive Technology	Per Item	85	13.00	76.66	84709.30	
Specialized Medical Supplies	Per Item	195	1978.00	0.97	374138.70	
<b>Speech Therapy Total:</b>						<b>79519.28</b>
Speech Therapy	15 min.	46	92.00	18.79	79519.28	
<b>Transportation Services Total:</b>						<b>1029149.40</b>
Transportation Services	1 mile	619	3260.00	0.51	1029149.40	
<b>GRAND TOTAL:</b>						<b>24822813.43</b>
Total Estimated Unduplicated Participants:						1511
Factor D (Divide total by number of participants):						16428.07
Average Length of Stay on the Waiver:						343

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and

Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Services Total:</b>						694065.92
Adult Day Services	15 min.	83	4448.00	1.88	694065.92	
<b>Habilitation Training Specialist Services Total:</b>						17205094.80
Habilitation Training Specialist Services	1 hour	1156	984.00	14.52	16516558.08	
Self Directed	1 hour	51	1103.00	12.24	688536.72	
<b>Homemaker Total:</b>						24435.00
Homemaker	1 hour	5	543.00	9.00	24435.00	
<b>Prevocational Services Total:</b>						2163481.20
Prevocational Services	1 hour	391	1044.00	5.30	2163481.20	
<b>Respite Total:</b>						44793.45
Respite	Per Day	31	19.00	76.05	44793.45	
<b>Supported Employment Total:</b>						2581446.40
Supported Employment	1 hour	284	760.00	11.96	2581446.40	
<b>Prescribed Drugs Total:</b>						117532.80
Prescribed Drugs	1 Rx Each	154	32.00	23.85	117532.80	
<b>Audiology Services Total:</b>						1315.44
Audiology Services	Per Service	8	3.00	54.81	1315.44	
<b>Dental Services Total:</b>						47707.38
Dental Services	Visit	147	6.00	54.09	47707.38	
<b>Environmental Accessibility Adaptations and Architectural Modification Total:</b>						18738.72
Environmental Accessibility Adaptations and Architectural Modification	Per Item	12	6.00	260.26	18738.72	
<b>GRAND TOTAL:</b>						25003109.09
Total Estimated Unduplicated Participants:						1571
Factor D (Divide total by number of participants):						15915.41
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Family Counseling Total:</b>						21253.05
Family Counseling	15 min.	7	195.00	15.57	21253.05	
<b>Family Training Total:</b>						246266.83
Individual Training	Session	8	45.00	41.39	14900.40	
Group Training	Session	23	47.00	214.03	231366.43	
<b>Nutrition Services Total:</b>						15898.96
Nutrition Services	15 min.	11	56.00	25.81	15898.96	
<b>Occupational Therapy Total:</b>						52520.00
Occupational Therapy	15 min.	26	101.00	20.00	52520.00	
<b>Physical Therapy Total:</b>						125080.00
Physical Therapy	15 min.	59	106.00	20.00	125080.00	
<b>Physician Services (provided by a Psychiatrist) Total:</b>						250.00
Physician Services (provided by a Psychiatrist)	30 min.	1	5.00	50.00	250.00	
<b>Psychological Services Total:</b>						50249.52
Psychological Services	15 min.	24	101.00	20.73	50249.52	
<b>Self Directed Goods and Services (SD-GS) Total:</b>						12849.90
Self Directed Goods and Services (SD-GS)	Per Item	10	7.00	183.57	12849.90	
<b>Specialized Medical Supplies and Assistive Technology Total:</b>						464678.48
Assistive Technology	Per Item	87	13.00	76.66	86702.46	
Specialized Medical Supplies	Per item	197	1978.00	0.97	377976.02	
<b>Speech Therapy Total:</b>						82976.64
Speech Therapy	15 min.	48	92.00	18.79	82976.64	
<b>Transportation Services Total:</b>						1032474.60
Transportation Services	1 mile	621	3260.00	0.51	1032474.60	
<b>GRAND TOTAL:</b>						25003109.09
Total Estimated Unduplicated Participants:						1571
Factor D (Divide total by number of participants):						15915.41
Average Length of Stay on the Waiver:						343

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (7 of 9)****d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Services Total:</b>						733475.20
Adult Day Services	15 min.	85	4448.00	1.94	733475.20	
<b>Habilitation Training Specialist Services Total:</b>						17807043.14
Habilitation Training Specialist Services	1 hour	1158	984.00	14.98	17069290.56	
Self Directed	1 hour	53	1103.00	12.62	737752.58	
<b>Homemaker Total:</b>						35273.28
Homemaker	1 hour	7	543.00	9.28	35273.28	
<b>Prevocational Services Total:</b>						2244297.24
Prevocational Services	1 hour	393	1044.00	5.47	2244297.24	
<b>Respite Total:</b>						49163.07
Respite	Per Day	33	19.00	78.41	49163.07	
<b>Supported Employment Total:</b>						2682222.40
Supported Employment	1 hour	286	760.00	12.34	2682222.40	
<b>Prescribed Drugs Total:</b>						122753.28
Prescribed Drugs	1 Rx Each	156	32.00	24.59	122753.28	
<b>Audiology Services Total:</b>						1695.30
Audiology Services	Per Service	10	3.00	56.51	1695.30	
<b>Dental Services Total:</b>						49858.38
Dental Services	Visit	149	6.00	55.77	49858.38	
<b>GRAND TOTAL:</b>						25993927.41
Total Estimated Unduplicated Participants:						1641
Factor D (Divide total by number of participants):						15840.30
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Environmental Accessibility Adaptations and Architectural Modification Total:</b>						22539.72
Environmental Accessibility Adaptations and Architectural Modification	Per Item	14	6.00	268.33	22539.72	
<b>Family Counseling Total:</b>						28185.30
Family Counseling	15 min.	9	195.00	16.06	28185.30	
<b>Family Training Total:</b>						278493.25
Individual Training	Session	10	45.00	42.68	19206.00	
Group Training	Session	25	47.00	220.67	259287.25	
<b>Nutrition Services Total:</b>						19379.36
Nutrition Services	15 min.	13	56.00	26.62	19379.36	
<b>Occupational Therapy Total:</b>						58313.36
Occupational Therapy	15 min.	28	101.00	20.62	58313.36	
<b>Physical Therapy Total:</b>						133328.92
Physical Therapy	15 min.	61	106.00	20.62	133328.92	
<b>Physician Services (provided by a Psychiatrist) Total:</b>						1288.75
Physician Services (provided by a Psychiatrist)	30 min.	5	5.00	51.55	1288.75	
<b>Psychological Services Total:</b>						56143.88
Psychological Services	15 min.	26	101.00	21.38	56143.88	
<b>Self Directed Goods and Services (SD-GS) Total:</b>						15898.68
Self Directed Goods and Services (SD-GS)	Per item	12	7.00	189.27	15898.68	
<b>Specialized Medical Supplies and Assistive Technology Total:</b>						489007.50
Assistive Technology	Per Item	89	13.00	79.04	91449.28	
Specialized Medical Supplies	Per Item	199	1978.00	1.01	397558.22	
<b>Speech Therapy Total:</b>						89148.00
<b>GRAND TOTAL:</b>						25993927.41
Total Estimated Unduplicated Participants:						1641
Factor D (Divide total by number of participants):						15840.30
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech Therapy	15 min.	50	92.00	19.38	89148.00	
<b>Transportation Services Total:</b>						1076419.40
Transportation Services	1 mile	623	3260.00	0.53	1076419.40	
<b>GRAND TOTAL:</b>						25993927.41
Total Estimated Unduplicated Participants:						1641
Factor D (Divide total by number of participants):						15840.30
Average Length of Stay on the Waiver:						343

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Services Total:</b>						750733.44
Adult Day Services	15 min.	87	4448.00	1.94	750733.44	
<b>Habilitation Training Specialist Services Total:</b>						17864363.50
Habilitation Training Specialist Services	1 hour	1160	984.00	14.98	17098771.20	
Self Directed	1 hour	55	1103.00	12.62	765592.30	
<b>Homemaker Total:</b>						45351.36
Homemaker	1 hour	9	543.00	9.28	45351.36	
<b>Prevocational Services Total:</b>						2255718.60
Prevocational Services	1 hour	395	1044.00	5.47	2255718.60	
<b>Respite Total:</b>						52142.65
Respite	Per Day	35	19.00	78.41	52142.65	
<b>Supported Employment Total:</b>						2700979.20
Supported Employment					2700979.20	
<b>GRAND TOTAL:</b>						26180465.71
Total Estimated Unduplicated Participants:						1721
Factor D (Divide total by number of participants):						15212.36
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	1 hour	288	760.00	12.34		
<b>Prescribed Drugs Total:</b>						124327.04
Prescribed Drugs	1 Rx Each	158	32.00	24.59	124327.04	
<b>Audiology Services Total:</b>						2034.36
Audiology Services	Per Service	12	3.00	56.51	2034.36	
<b>Dental Services Total:</b>						50527.62
Dental Services	Visit	151	6.00	55.77	50527.62	
<b>Environmental Accessibility Adaptations and Architectural Modification Total:</b>						25759.68
Environmental Accessibility Adaptations and Architectural Modification	Per Item	16	6.00	268.33	25759.68	
<b>Family Counseling Total:</b>						34448.70
Family Counseling	15 min.	11	195.00	16.06	34448.70	
<b>Family Training Total:</b>						303077.43
Individual Training	Session	12	45.00	42.68	23047.20	
Group Training	Session	27	47.00	220.67	280030.23	
<b>Nutrition Services Total:</b>						22360.80
Nutrition Services	15 min.	15	56.00	26.62	22360.80	
<b>Occupational Therapy Total:</b>						62478.60
Occupational Therapy	15 min.	30	101.00	20.62	62478.60	
<b>Physical Therapy Total:</b>						137700.36
Physical Therapy	15 min.	63	106.00	20.62	137700.36	
<b>Physician Services (provided by a Psychiatrist) Total:</b>						1804.25
Physician Services (provided by a Psychiatrist)	30 min.	7	5.00	51.55	1804.25	
<b>Psychological Services Total:</b>						60462.64
Psychological Services					60462.64	
<b>GRAND TOTAL:</b>						26180465.71
Total Estimated Unduplicated Participants:						1721
Factor D (Divide total by number of participants):						15212.36
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 min.	28	101.00	21.38		
<b>Self Directed Goods and Services (SD-GS) Total:</b>						<b>18548.46</b>
Self Directed Goods and Services (SD-GS)	Per item	14	7.00	189.27	18548.46	
<b>Specialized Medical Supplies and Assistive Technology Total:</b>						<b>495058.10</b>
Assistive Technology	Per Item	91	13.00	79.04	93504.32	
Specialized Medical Supplies	Per Item	201	1978.00	1.01	401553.78	
<b>Speech Therapy Total:</b>						<b>92713.92</b>
Speech Therapy	15 min.	52	92.00	19.38	92713.92	
<b>Transportation Services Total:</b>						<b>1079875.00</b>
Transportation Services	1 mile	625	3260.00	0.53	1079875.00	
<b>GRAND TOTAL:</b>						<b>26180465.71</b>
Total Estimated Unduplicated Participants:						1721
Factor D (Divide total by number of participants):						15212.36
Average Length of Stay on the Waiver:						343

## Appendix J: Cost Neutrality Demonstration

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

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Services Total:</b>						<b>767991.68</b>
Adult Day Services	15 min.	89	4448.00	1.94	767991.68	
<b>Habilitation Training Specialist Services Total:</b>						<b>17921683.86</b>
Habilitation Training Specialist Services	1 hour	1162	984.00	14.98	17128251.84	
Self Directed	1 hour	57	1103.00	12.62	793432.02	
<b>GRAND TOTAL:</b>						<b>26367004.01</b>
Total Estimated Unduplicated Participants:						1780
Factor D (Divide total by number of participants):						14812.92
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Homemaker Total:</b>						55429.44
Homemaker	1 hour	11	543.00	9.28	55429.44	
<b>Prevocational Services Total:</b>						2267139.96
Prevocational Services	1 hour	397	1044.00	5.47	2267139.96	
<b>Respite Total:</b>						55122.23
Respite	Per Day	37	19.00	78.41	55122.23	
<b>Supported Employment Total:</b>						2719736.00
Supported Employment	1 hour	290	760.00	12.34	2719736.00	
<b>Prescribed Drugs Total:</b>						125900.80
Prescribed Drugs	1 Rx Each	160	32.00	24.59	125900.80	
<b>Audiology Services Total:</b>						2373.42
Audiology Services	Per Service	14	3.00	56.51	2373.42	
<b>Dental Services Total:</b>						51196.86
Dental Services	Visit	153	6.00	55.77	51196.86	
<b>Environmental Accessibility Adaptations and Architectural Modification Total:</b>						28979.64
Environmental Accessibility Adaptations and Architectural Modification	Per Item	18	6.00	268.33	28979.64	
<b>Family Counseling Total:</b>						40712.10
Family Counseling	15 min.	13	195.00	16.06	40712.10	
<b>Family Training Total:</b>						327661.61
Individual Training	Session	14	45.00	42.68	26888.40	
Group Training	Session	29	47.00	220.67	300773.21	
<b>Nutrition Services Total:</b>						25342.24
Nutrition Services	15 min.	17	56.00	26.62	25342.24	
<b>GRAND TOTAL:</b>						26367004.01
Total Estimated Unduplicated Participants:						1780
Factor D (Divide total by number of participants):						14812.92
Average Length of Stay on the Waiver:						343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Occupational Therapy Total:</b>						<b>66643.84</b>
Occupational Therapy	15 min.	32	101.00	20.62	66643.84	
<b>Physical Therapy Total:</b>						<b>142071.80</b>
Physical Therapy	15 min.	65	106.00	20.62	142071.80	
<b>Physician Services (provided by a Psychiatrist) Total:</b>						<b>2319.75</b>
Physician Services (provided by a Psychiatrist)	30 min.	9	5.00	51.55	2319.75	
<b>Psychological Services Total:</b>						<b>64781.40</b>
Psychological Services	15 min.	30	101.00	21.38	64781.40	
<b>Self Directed Goods and Services (SD-GS) Total:</b>						<b>21198.24</b>
Self Directed Goods and Services (SD-GS)	Per item	16	7.00	189.27	21198.24	
<b>Specialized Medical Supplies and Assistive Technology Total:</b>						<b>501108.70</b>
Assistive Technology	Per Item	93	13.00	79.04	95559.36	
Specialized Medical Supplies	Per Item	203	1978.00	1.01	405549.34	
<b>Speech Therapy Total:</b>						<b>96279.84</b>
Speech Therapy	15 min.	54	92.00	19.38	96279.84	
<b>Transportation Services Total:</b>						<b>1083330.60</b>
Transportation Services	1 mile	627	3260.00	0.53	1083330.60	
<b>GRAND TOTAL:</b>						<b>26367004.01</b>
Total Estimated Unduplicated Participants:						<b>1780</b>
Factor D (Divide total by number of participants):						<b>14812.92</b>
Average Length of Stay on the Waiver:						<b>343</b>