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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

A. The **State** of **Oklahoma** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
B. **Program Title:**
Medically Fragile
C. **Waiver Number:OK.0811**
D. **Amendment Number:OK.0811.R01.03**
E. **Proposed Effective Date:** *(mm/dd/yy)*
04/01/16
Approved Effective Date: 04/01/16
Approved Effective Date of Waiver being Amended: 07/01/13

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
OHCA is submitting this amendment to reduce provider rates.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A – Waiver Administration and Operation	
☐ Appendix B – Participant Access and Eligibility	
☐ Appendix C – Participant Services	
☐ Appendix D – Participant Centered Service Planning and Delivery	

☐ **Appendix E – Participant Direction of Services**	
☐ **Appendix F – Participant Rights**	
☐ **Appendix G – Participant Safeguards**	
☐ **Appendix H**	
☐ **Appendix I – Financial Accountability**	
☑ **Appendix J – Cost-Neutrality Demonstration**	

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

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

  Specify:
  Provider rate reduction

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

1. Request Information (1 of 3)

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

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

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Waiver Number:OK.0811.R01.03
Draft ID: OK.010.01.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/13
Approved Effective Date of Waiver being Amended: 07/01/13

1. Request Information (2 of 3)

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

☑ **Hospital**

Select applicable level of care

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

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

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

☑ **Nursing Facility**

Select applicable level of care

- ◉ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

- ◉ **Not applicable**
- ○ **Applicable**

Check the applicable authority or authorities:

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

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

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

  - ☐ **§1915(b)(1) (mandated enrollment to managed care)**
  - ☐ **§1915(b)(2) (central broker)**
  - ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
  - ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

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

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

- ☐ **A program authorized under §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☐ **A program authorized under §1115 of the Act.**

  Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The State of Oklahoma requests to amend the 1915(c) Home and Community-Based Services Waiver for Medicaid members who have been diagnosed with a medically fragile condition who require a Hospital/Skilled Nursing Facility (H/SNF) level of care (LOC) and whose needs could not otherwise be met through another Oklahoma Waiver. A medically fragile condition is defined as a chronic physical condition, which results in prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following:
(1) There is a life threatening condition characterized by reasonably frequent periods of acute exacerbation which requires frequent medical supervision, and/or physician consultation and which in the absence of such supervision or consultation would require hospitalization.
(2) The individual requires frequent time consuming administration of specialized treatments which are medically necessary.
(3) The individual is dependent on medical technology such that without the technology a reasonable level of health could not be maintained. Examples include but are not limited to dependence on ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen.

The goal of this program is to provide services which allow Medicaid eligible persons who need hospital and/or skilled nursing facility level of care to remain at home or in the residential setting of their choosing while receiving the necessary care. The Medically Fragile Program is a home and community-based alternative to placement in a hospital and/or skilled nursing facility to receive Medicaid-funded assistance for care. This waiver also incorporates self-direction opportunities for a specified group of services such as Advanced Supportative Restorative/Assistance (ASR),Personal Care and Respite as a service delivery mechanism.

Under the Medically Fragile Waiver Program, Oklahomans who qualify will receive the following services:
* Advanced Supportive/Restorative Assistance
* Case Management Services
* Environmental Modifications
* Home Delivered Meals
* Hospice Care
* Institutional Transiton Services
* Occupational Therapy
* Personal Care
* Prescribed Drugs
* Personal Emergency Response System (PERS)
* Physical Therapy
* Private Duty Nursing
* Respiratory Therapy
* Respite
* Skilled Nursing
* Specialized Medical Equipment and Supplies
* Self-Directed Goods and Services
* Speech Therapy

The Medically Fragile home and community-based waiver program is a State of Oklahoma Medicaid program operated by the Oklahoma Health Care Authority. As a Medicaid program, federal and state guidelines, rules, regulations and laws govern the operation of the program. At the state level, authority for the operation of Medicaid programs rests with the Oklahoma Health Care Authority (OHCA), the State Medicaid Agency. Services are provided by qualified providers who have entered into provider agreements with OHCA.

3. Components of the Waiver Request

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

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- (●) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

(Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

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

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
The following processes and forums have provided opportunity for public input to the waiver amendment process:

On November 3,2015 & November 19, 2015 the OHCA SoonerCare Tribal Consultation Meetings included a presention on the proposed amendment included in this request. There were no comments received regarding this amendment. No additiional follow-up questions were received.

On November 18, 2015 providers were notified of the proposed reductions through the OHCA Provider Checkup Newsletter.

On December 1, 2015 the OHCA posted a copy of this amendment to their public web-site for a 30-day public comment.

The agency has continued to make public input a priority in the ongoing operations of this waiver.

In December 2015, OHCA had notices published in the five largest newspapers (Daily Oklahoman, Tulsa World, Lawton Constitution, Norman Transcript and Tulsa Business & Legal News (Broken Arrow). The notices informed the community of the public meeting, date, time and location.

On December 9, 2015 the State Plan Amendment Rate Committee met to consider the proposed provider rate cut for the Medically Fragile Waiver program. The State Plan Amendment Rate Committee approved the proposed reductions.

Finally, the OHCA Board of Directors approved the proposed provider rate reductions at the December 10, 2015 meeting.

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

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

7. Contact Person(s)

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

Last Name: Antwine

First Name: LeKenya

Title: Waiver Administration Coordinator

Agency: Oklahoma Health Care Authority

Address: 4345 North Lincoln Blvd.

Address 2:

City: Oklahoma City

State: **Oklahoma**

Zip: 73105

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

Fax: (405) 530-3408

E-mail: lekenya.antwine@okhca.org

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Oklahoma**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to

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

Signature: Nico Gomez

State Medicaid Director or Designee

Submission Date: Mar 2, 2016

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

Last Name: Manzo de Puebla

First Name: Sandra

Title: Federal Authorities Coordinator

Agency: Oklahoma Health Care Authority

Address: 4345 N. Lincoln Blvd.

Address 2:

City: Oklahoma City

State: **Oklahoma**

Zip: 73105

Phone: (405) 522-7321 **Ext:** ☐ ☐ **TTY**

Fax: (405) 530-3416

E-mail: sandra.puebla@okhca.org

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

When transitioning a member from another Home and Community-Based (HCBS) Waiver into the Medically Fragile Waiver all efforts will be made to ensure the member's health and safety needs are met and to provide the member and his/her legal representative the opportunity to choose waiver services or institutional care. Members currently being served in another approved HCBS waiver who are deemed eligible to participate in the Medically Fragile waiver will be offered the opportunity to be transitioned to enroll in the Medically Fragile program or may choose institutional services.

A Medically fragile condition is defined as a chronic physical condition which results in prolonged dependency on medical care for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following:
(1) There is a life threatening condition characterized by reasonably frequent periods of acute exacerbation which requires frequent medical supervision, and/or physician consultation and which in the absence of such supervision or consultation would require hospitalization.
(2) The individual requires frequent, time consuming administration of specialized treatments which are medically necessary.
(3) The individual is dependent on medical technology such that without the technology a reasonable level of health could not be maintained. Examples include but are not limited to dependence on ventilators, dialysis machines, enteral or parenteral nutrition support and continuous oxygen.

As waiver operations begin members enrolled in existing waivers are assessed and referred for evaluation and possible entrance into the Medically Fragile Waiver program. This consideration for referral to the Medically Fragile Waiver may also occur during annual re-evaluation and as changes to the member's medical conditions are identified.

Members and their legal representatives are informed in writing by the OHCA staff and by the case manager if a member cannot be appropriately served in the Medically Fragile Waiver. The case manager serving the member in the current waiver will work with the member and his/her legal representative to ensure that the current waiver or institutional or community supports are developed to meet the needs of the member.

The member and their legal representatives are informed in writing of their rights to receive a fair hearing regarding any decision with potential adverse impact on the member including choice of service setting (institution or waiver services), choice of provider or of service, or denial, reduction, suspension or termination of services. Appeals regarding services are directed to the OHCA. Members also receive written information regarding the right to request a Fair Hearing and the steps in the appeals process with respect to services. The member is to use the LD-1 form to file a request. The LD-1 form is to be mailed to:
Oklahoma Health Care Authority
Grievance Docket Clerk
Legal Division
P.O. Drawer 18497
Oklahoma City, Oklahoma 73154-0497

OHCA Fax Number is (405) 530-3444
OHCA Docket Clerk Telephone Number is (405) 522-7217

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

Oklahoma Transition Plan for HCBS Setting Compliance for the Medically Fragile Waiver (0811)

Purpose:
The purpose of this Transition Plan is to ensure the individuals receiving Home and Community-Based Services (HCBS) are integrated in and have access to supports in the community, including opportunities to seek employment, work in competitive integrated settings, engage in community life, and control personal resources. Overall, the Transition Plan provides assurance that the individuals receiving HCBS have the same degree of access as individuals not receiving Medicaid HCBS. This Transition Plan outlines the proposed process that Oklahoma will be utilizing to ensure implementation of the new HCBS requirements. Stakeholders are being asked to provide public input and comment in order to allow Oklahoma to develop a comprehensive assessment plan.
The transition plan will include:
• A 30-day public comment period of the draft transition plan;
• A response summary of public comments received;
• A plan to review applicable state standards, rules, regulations and policies;
• A plan for assessing HCBS settings;
• A time frame for a summary of how each setting meets or does not meet the federal HCBS setting requirements;
• A plan for ensuring the health and safety of members who reside in locations that need to meet corrective action requirements for the setting to come into compliance during the states specified transition time.

The state utilized the Raosoft sample size calculator to determine a valid sample size.

The state will submit an amendment to provide updated information on the waiver specific tranition plan with a project date of January'2017.

Oklahoma's Assessment Plan for HCBS Requirements

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

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

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

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

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

In conjunction with the assessment tool and provider surveys, an assessment of Oklahoma policies and procedures will be completed to identify compliance/noncompliance with the new federal HCBS rules. More specifically, a systematic review of:
• Provider Enrollment and Re-Approval Requirements
• Current trainings to integrate the new HCBS requirement
• Operational Manual and Service Definition
• Applicable Licensure Act (Adult Day and Nursing etc.)

Phase 3- Programmatic Data Assessment
Start Date: July 2015

End Date: October 2015

Information obtained from the analysis of internal programmatic data and transition plan assessments, surveys, and site visits will be utilized to identify areas of compliance and noncompliance. The data and the identified areas of noncompliance will be used to gather further qualitative feedback from providers, members, and their families. Input will be gathered through a variety of means that include but are not limited to:
• Member focused groups/and or surveys
• Focus groups with service provider and DHS and/or OHCA staff
• Site visits
• Advocacy groups
• Long-Term Care Quality Initiatives Council and Living Choice Advisory Committee

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

OHCA will develop an inventory and description of HCBS settings types and summarize how each setting meets or does not meet the federal HCBS requirements. Review and analysis will be conducted from the following sources:
• Provider Surveys
• Family/ Participant interviews,etc
• Site visits
• Stakeholder input
• Internal programmatic data

Phase 5- Compliamce and Noncompliance Assessment
Start Date: July 2015
End Date: September 2015

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

To ensure the State Remedial practice:
• The State will conduct case management training, member and provider surveys and periodic site visits to ensure compliance
• The state will continue on an annual basis to review NCI data, conduct phone surveys and periodic compliance site visits
• When warranted the state will require a 30 day corrective action plan
• The state will follow-up with the provider at the expiration of the corrective action plan to ensure compliance

Below is an uncomprehensive summary of the assessment plan activities that Oklahoma will utilize to develop an extensive transition plan in accordance with HCBS final rule:

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

Assessment Activity
Analyze data from responses gathered through the following activities:
• National Core Indicators
• Oklahoma Advocates Involved in Monitoring (OK AIM) Survey
• HCBS Requirements
• Site Visits
• Interviews
• Stakeholder Meetings

Examples of information gathered from these activities is as follows:
• Individual interacts with neighbors
• Extent to which people do certain activities in the community

• Individual has a paid job in the community

Start Date End Date
1/2015 3/2015

HCBS Rule
REQUIREMENT: Control personal resources

Assessment Activity
Analyze data from responses gathered through the following activities:

• National Core Indicators
• Oklahoma Advocates Involved in Monitoring (OK AIM) Survey
• HCBS Requirements
• Site Visits
• Interviews
• Stakeholder Meetings

Examples of information gathered from these activities is as follows:
• Individual can decide how to spend his/her own money
• Individual can access personal funds

Start Date End Date
1/2015 3/2015

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

Assessment Activity
Analyze data from responses gathered through the following activities:
• National Core Indicators
• Oklahoma Advocates Involved in Monitoring (OK AIM) Survey
• HCBS Requirements
• Site Visits
• Interviews
• Stakeholder Meetings

Examples of information gathered from these activities is as follows:
• Individuals have a variety of recreation/leisure opportunities
• Individual interacts with neighbors

Start Date End Date
1/2015 3/2015

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

Assessment Activity
Analyze data from responses gathered through the following activities:
• National Core Indicators
• Oklahoma Advocates Involved in Monitoring (OK AIM) Survey
• HCBS Requirements
• Site Visits
• Interviews
• Stakeholder Meetings

Examples of information gathered from these activities is as follows:
• Setting was selected by the individual
• Choose or had input in where they go during the day
• Choose Free Time

Start Date End Date
1/2015 3/2015

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

Assessment Activity
Analyze data from responses gathered through the following activities:

• National Core Indicators
• Oklahoma Advocates Involved in Monitoring (OK AIM) Survey
• HCBS Requirements
• Site Visits
• Interviews
• Stakeholder Meetings

Examples of information gathered from these activities is as follows:
• Staff interacts positively and with respect towards everyone
• Individual has privacy; mail/email is not read without permission, etc.

Start Date End Date
1/2015 3/2015

HCBS Rule
REQUIREMENT: Setting is physically accessible to the individual

Assessment Activity
Analyze data from responses gathered through the following activities:
• National Core Indicators
• Oklahoma Advocates Involved in Monitoring (OK AIM) Survey
• HCBS Requirements
• Site Visits
• Interviews
• Stakeholder Meetings

Examples of information gathered from these activities is as follows:
• Home has adaptations and is accessible

Start Date End Date
1/2015 3/2015

HCBS Rule
REQUIREMENT: Privacy in their unit including entrances lockable by the individual

Assessment Activity
Analyze data from responses gathered through the following activities:
• National Core Indicators
• Oklahoma Advocates Involved in Monitoring (OK AIM) Survey
• HCBS Requirements
• Site Visits
• Interviews
• Stakeholder Meetings

Examples of information gathered from these activities is as follows:
• If others announce themselves before entering home
• If others announce themselves before entering bedroom
• If individual has enough privacy

Start Date End Date
1/2015 3/2015

HCBS Rule

REQUIREMENT: Visitors at any time

Assessment Activity
Analyze data from responses gathered through the following activities:
• National Core Indicators
• Oklahoma Advocates Involved in Monitoring (OK AIM) Survey
• HCBS Requirements
• Site Visits
• Interviews
• Stakeholder Meetings

Examples of information gathered from these activities is as follows:
• Individuals have control over their own lives
• Whether individual can be alone with visitors or if there are some rules/restrictions
• Relationships are encouraged and supported

Start Date End Date
1/2015 3/2015

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

Assessment Activity
Analyze data from responses gathered through the following activities:
• National Core Indicators
• Oklahoma Advocates Involved in Monitoring (OK AIM) Survey
• HCBS Requirements
• Site Visits
• Interviews
• Stakeholder Meetings

Examples of information gathered from these activities is as follows:
• Choose or had some input in choosing their roommates
• If individuals choose to live alone, or choose people they live with

Start Date End Date
1/2015 3/2015

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

Assessment Activity
Analyze data from responses gathered through the following activities:
• National Core Indicators
• Oklahoma Advocates Involved in Monitoring (OK AIM) Survey
• HCBS Requirements
• Site Visits
• Interviews
• Stakeholder Meetings

Examples of information gathered from these activities is as follows:
• The house reflects the personalities of the individual

Start Date End Date
1/2015 3/2015

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

Assessment Activity
Analyze data from responses gathered through the following activities:
• National Core Indicators

• Oklahoma Advocates Involved in Monitoring (OK AIM) Survey
• HCBS Requirements
• Site Visits
• Interviews
• Stakeholder Meetings

Examples of information gathered from these activities is as follows:
• Individuals feel empowered by the decisions they make
• Individuals make as many daily choices as they can
• Individuals have control over their lives
• Individuals are included in running the household

Start Date End Date
1/2015 3/2015

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

Assessment Activity
Analyze data from responses gathered through the following activities:
• National Core Indicators
• Oklahoma Advocates Involved in Monitoring (OK AIM) Survey
• HCBS Requirements
• Site Visits
• Interviews
• Stakeholder Meetings

Examples of information gathered from these activities is as follows:
• Individuals are given a choice among qualified providers and the choice has been documented properly
• Individual chose their home, job, day program or activity staff
• Individual receives services they need
• Individual assisted in the development of the service plan

Start Date End Date
1/2015 3/2015

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

Assessment Activity
Analyze data from responses gathered through the following activities:
• National Core Indicators
• Oklahoma Advocates Involved in Monitoring (OK AIM) Survey
• HCBS Requirements
• Site Visits
• Interviews
• Stakeholder Meetings

Examples of information gathered from these activities is as follows:
• Individuals or their informal/natural supporters hold a lease or written residency agreement for the setting
• Written agreement includes language that provides protection against protection and allows appeals of eviction notices

Start Date End Date
1/2015 3/2015

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

Assessment Activity
Analyze data from responses gathered through the following activities:
• National Core Indicators

• Oklahoma Advocates Involved in Monitoring (OK AIM) Survey
• HCBS Requirements
• Site Visits
• Interviews
• Stakeholder Meetings

Examples of information gathered from these activities is as follows:
• Individual lives in or receives HCBS services in an area of the setting which is not separate from individuals not receiving Medicaid services.

The state assures that the settings transition plan included with this waiver amendment or renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Start Date End Date
1/2015 3/2015

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

   (●) **The waiver is operated by the State Medicaid agency.**

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

   (●) **The Medical Assistance Unit.**

   Specify the unit name:
   Long Term Care Waiver Operations (LTCWO)
   (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:

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the

administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

   - (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
     Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
     The contracted Fiscal Management Services (FMS) provider performs waiver operational and administrative functions. The FMS assists members who self-direct services with all payroll, spending plans, claims filed and processed and provider enrollment functions.
   - ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

   - (●) **Not applicable**
   - ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
     - [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that

is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
OHCA's Long Term Care Waiver Operations Division has responsibility for assessing the performance of the FMS. The contract monitor is the Senior Program Manager.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The FMS performance is monitored by the Long Term Care Waiver Operations Senior Program Manager based on contract performance standards. The contractors are responsible for providing, at a minimum, monthly reports of activities furnished in support of waiver members. These reports are analyzed by the Senior Program Manager. On a quarterly basis, the Senior Program Manager assesses performance and reports findings to the LTCQIC. On a quarterly basis, the State will also consider member complaint data recorded in the Member Inquiry Tracking System in evaluating performance on a montly basis. Although contractor performance is monitored daily by the Senior Program Manager on an ongoing basis, formal performance assessment of these contractors occurs at least twice each year in semi-annual readiness reviews for contractors and operational compliance reviews.

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	Contracted Entity
Participant waiver enrollment	☑	☐

Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☑	☐
Review of Participant service plans	☑	☐
Prior authorization of waiver services	☑	☐
Utilization management	☑	☑
Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☐
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percentage of spending plans administered by the FMS that followed Medicaid approved requirements. Denominator: Total number of spending plans. Numerator: Spending plans administered that followed requirements.

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

FMS monthly report

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

Data Aggregation and Analysis:

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

Performance Measure:
Number of quarterly LTCWO administrative reports prepared/furnished within 10

working days of the close of the quarter. Denominator: Number of reports orepared/furnished quarterly. Numerator: Number of reports prepared/furnished within 10 days of close of quarter.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report prepared by LTCWO staff

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

Data Aggregation and Analysis:

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

	Specify:

Performance Measure:
Number and percentage of Providers enrolled quarterly by the FMS that met provider qualifications prior to performing services for members choosing self-direction. Denominator: Individual providers enrolled by the FMS to perform services for members choosing self-direction. Numerator: Providers that met qualifications prior to performing services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FMS monthly provider qualifications report

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Percentage of payroll functions reported monthly by the FMS that were submitted on time and in correct format as specified in the agreement with OHCA. Denominator: Total payroll functions reports required. Numerator: Total reports received timely and in the correct format.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Long Term Care Waiver Operations dedicated staff are reponsible 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 entites. Waiver staff will maintain adminstrative authority through the use of an electronic database designed for storing information received related to problems identified and resolutions of these matters. The Long Term Care Waiver Operations Contract Monitor will be directly responsible for mediating any individual problems pertaining to administrative authority. The LTCWO Contract Monitor will work with the designated Contractor Point of Contact to resolve any problems in a timely manner. The LTCWO Contract Monitor will have the use of penalties and sanctions in accordance with the terms of the contract. Problems requiring additional OHCA staff will be addressed in workgroups involving appropriate personnel to resolve issues timely and effectively. These problems and resolutions will also be reported in the LTCQIC meetings.

ii. Remediation Data Aggregation

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

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
[ ] Aged or Disabled, or Both - General					
	[ ]	Aged			[ ]
	[ ]	Disabled (Physical)			
	[ ]	Disabled (Other)			
[x] Aged or Disabled, or Both - Specific Recognized Subgroups					
	[ ]	Brain Injury			[ ]
	[ ]	HIV/AIDS			[ ]
	[x]	Medically Fragile	19		[x]
	[x]	Technology Dependent	19		[x]
[ ] Intellectual Disability or Developmental Disability, or Both					
	[ ]	Autism			[ ]
	[ ]	Developmental Disability			[ ]
	[ ]	Intellectual Disability			[ ]
[ ] Mental Illness					
	[ ]	Mental Illness			
	[ ]	Serious Emotional Disturbance			

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

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

behalf of participants affected by the age limit *(select one):*

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ( ) **Other**

    Specify:

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	90
Year 2	90
Year 3	110
Year 4	130
Year 5	155

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	

Emergency
Program Age Out
Other HCBS Waiver

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):*

Emergency

Purpose *(describe):*

If an individual is eligible for SoonerCare and meets the criteria for the medically fragile waiver, and is experiencing a crisis or emergency, that individual may be transitioned to this waiver program. This enrollment will provide for home and community-based services to avert immediate risks to the members' health and welfare.

Describe how the amount of reserved capacity was determined:

The amount has been determined based on estimates furnished by program administrators involved in the operation of other waivers and programs.

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

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

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):*

Program Age Out

Purpose *(describe):*

If a member who is served in a SoonerCare program ages out of that program but meets the criteria for the Medically Fragile waiver capacity is reserved to meet this need.

Describe how the amount of reserved capacity was determined:

The amount has been determined based on estimates furnished by program administrators involved in the operation of other waivers and programs.

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

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

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):*

Other HCBS Waiver

Purpose *(describe):*

If a member who is served in another HCBS Waiver has a change of condition and meets criteria for the Medically Fragile waiver, the member may be transitioned to this waiver program.

Describe how the amount of reserved capacity was determined:

The amount has been determined based on estimates furnished by program administrators involved in the operation of other waivers and programs.

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

The Medically Fragile Waiver provides for the entrance of all eligible persons on a first come first serve basis.

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:

- [x] **A special income level equal to:**

Select one:

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

Specify percentage:

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

Specify dollar amount:

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

Select one:

○ **100% of FPL**
○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.** *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

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

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

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

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- (●) **The following standard included under the State plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional State supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

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

      Specify the percentage:
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage:
  - ( ) **Other standard included under the State Plan**

    Specify:
- ( ) **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:
- ( ) **Other**

  Specify:

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

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

Specify:

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

- ( ) **SSI standard**
- ( ) **Optional State supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

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

- ( ) **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

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

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

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

Specify percentage:

- ○ **The following dollar amount:**

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

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

Specify formula:

○ **Other**

Specify:

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

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The State does not establish reasonable limits.**

○ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- ( ) **Other**
Specify:

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

A registered nurse or licensed practical nurse licensed in the State of Oklahoma with one year paid professional experience with aging and/or disabled populations or programs as a case manager, a rehabilitation specialist or health specialist and/or social services coordinator who has successfully completed the Uniform Comprehensive Assessment Tool (UCAT) training offered or approved by OHCA.

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.

(1) Level of care medical eligibility determination
The OHCA registered nurse, or nurse designee determines medical eligibility for Medically Fragile program services based on the Uniform Comprehensive Assessment Tool (UCAT) III assessment and the determination that the member has unmet care needs that require Medically Fragile waiver or hospital/skilled nursing facility services to assure member's health and safety.

(2) Minimum UCAT criteria. The minimum UCAT criteria for hospital or skilled nursing facility level of care criteria are delineated in the assessment tool.
(A) The UCAT documents that:
(i) the member has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet eligibility criteria if untreated; and
(ii) the member previously has required Hospital or Skilled Nursing facility level of care services for treatment related to the condition; and
(iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and
(iv) only by means of Medically Fragile program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process: otherwise, the individual could seek services in a hospital and/or nursing facility.
(B) The UCAT documents absence of support to meet the needs to sustain health and safety; and
(C) The UCAT documents need for assistance to sustain health and safety as demonstrated by ADLs in the high risk range.
If the member's LOC determination is denied, the member will be notified in writing as to their right to a fair hearing by the Long Term Care Waiver Operations Division.

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:

OHCA nurses and provider agency case managers will conduct an assessment using the UCAT instrument, establishing the level of care. The document is forwarded to OHCA for monitoring and tracking. OHCA Care Management Team will review and approve the member to be enrolled in the waiver. This process is followed annually during member re-evaluation. If the member's level of care determination is denied, the member will be notified in writing as to their right to appeal and the right to a fair hearing by the Long Term Care Waiver Operations division. All initial UCAT's are completed by the Medicaid Agency. Re-Assessment UCAT's are completed by the Case Management agency. All level of care deteminations are established by the OHCA nursing staff.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

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

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

  Specify the qualifications:

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

•ATLANTES is a clinician-designed system which alerts providers of re-evaluations due and provides a single view of member information for care coordination. This system is also used to edit and create reports for OHCA, LTCWO and the Care Management team. One report that is generated by the system is the "re-evaluations due in 60 days report," which serves as an alert to assist the State in ensuring that re-evaluations are performed timely.

•This is a component part of case management considered as part of required annual service plan reevaluation process.

•The Provider Agency is required to track each level of care expiration date in order to meet the required sixty day renewal process.

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 OHCA Care Manager and the Provider Agency must maintain this information in accordance with record retention requirements as required by state law. The OHCA records are maintained within the MMIS and ATLANTES systems and a hard copy/CD (microfilm) is maintained in the OHCA Long Term Care Waiver Operations Division. The provider agency is responsible for maintaining the documentation at the provider agency site for three years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
Number and percent of new enrollees who met level of care prior to receiving Medically Fragile Waiver Services. Denominator: Total number of new enrollees. Numerator: Total number of new enrollees who met level of care.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ATLANTES and Long Term Care Waiver Operations report

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and Percentage of Re-evaluations performed within 12 months of the initial Level of Care evaluation or within 12 months of their last annual LOC evaluation. Denominator: Number of Level of Care Re-evaluations due. Numerator: Number of Level of Care Re-evaluations performed timely.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ATLANTES, MMIS, and LTCWO report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: 60 days prior to re-evaluation date	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

	60 days prior to re-evaluation date

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

Performance Measures

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

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

Performance Measure:
Number and percent of members initial LOC determinations instruments that were completed as required by the State. Numerator:Total number of LOC determination instruments completed as required by the State. Denominator: Total number of initial LOC determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Long Term Care Waiver Operations Report and ATLANTES.

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of members annual(re-evaluations) LOC determinations instruments that were completed as required by the State. Numerator: Total number of LOC determination instruments completed as required by the State. Denominator: Total number of annual LOC determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Long Term Care Waiver Operations Reports and ATLANTES.

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When the OHCA Care Management team detects non-compliance in administering the LOC tool, the Care Management team will provide corrective training intervention to the nurse. The supervisor will review all level of care evaluations by the nurse until the supervisor determines that the nurse has demonstrated proper compliance in administering the level of care tool. These performance issues are noted by the nurse supervisor in the personnel file as appropriate.

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

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

☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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

◉ **No**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Each member is provided the Medically Fragile, Freedom of Choice form by the Provider Agency Case Manager, describing the rights to review alternatives and choose either institutional or waiver services. A service plan is developed before entrance into the waiver program. The plan is based on the findings of the assesment and will help the individual understand the options available for participation in the waiver. The service plan is developed with the full participation of the individual or his/her legal guardian or other representatives.

Specifically, the individual service plan provides the following information:
* all services, including objectives and expected duration of each service element the individual's desired outcomes
* the available options and services available in the community
* the benefits and services available through the waiver
* informs the individual, his or her family members, legal guardian, advocate or other representative about the benefits, risks and alternatives to planned services
* freedom of choice to reside in a qualified community residence (A qualified community residence is defined as a home leased or owned by the individual; an apartment leased by the individual or a residence in which no more than four individuals reside).

* a source of income
* accessible health care
* transportation
* access to peer support
* access to natural support (if available)

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 Medically Fragile, Freedom of Choice form must be completed and signed upon initial entrance into the waiver and will be maintained in the member's file at the provider agency and a copy will be sent to the LTCWO staff for tracking and will be maintained for a minimum of three years as specified in the OHCA records retention policy and 45 C.F.R. 92.42.

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):
OHCA has contracted access to a language line through its enrollment broker contract. Additionally, OHCA employs bilingual staff, who speak English and Spanish or English and Vietnamese to assist the members and/or provider agency staff with any language needs.

OHCA performs a quarterly analysis of race and ethnicity of all 1915(c) waiver members to determine if prevalence of a specific population is established. OHCA considers ten percent a threshold for preparing materials in other languages. In December 2012 the Hispanic population in 1915(c) waivers comprised 2.09% of the total in these waivers. No other race or ethnicity has been identified that would require translation to a language other than English. However, OHCA remains committed to ensuring that meaningful access to the waiver is afforded to persons with limited English proficiency. OHCA will continually survey/assess the needs of eligible service populations in order to determine whether certain critical outreach materials should be translated into other languages. Further, OHCA will provide assistance as needed to assist persons with Limited English Proficiency with access to services.

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	**Case Management**	
Statutory Service	**Personal Care**	
Statutory Service	**Respite**	
Extended State Plan Service	**Prescribed Drugs**	
Other Service	**Advanced Supportive/Restorative Assistance**	
Other Service	**Environmental Modifications**	
Other Service	**Home Delivered Meals**	
Other Service	**Hospice Care**	
Other Service	**Institutional Transition Services**	
Other Service	**Personal Emergency Response System (PERS)**	
Other Service	**Private Duty Nursing**	
Other Service	**Self-Directed Goods and Services (SD-GS)**	
Other Service	**Skilled Nursing**	
Other Service	**Specialized Medical Equipment and Supplies**	

Other Service	**Therapy Services: Respiratory**
Other Service	**Therapy Services: Occupational**
Other Service	**Therapy Services: Physical**
Other Service	**Therapy Services: Speech**

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope)*:

1. Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source, that may benefit the member in maintaining health and safety. 2. Case managers ensure that the individual's needs are met in self-direction through linkage, assessment, brokerage, advocacy and monitoring activities. 3. Specifically, the case manager performs the following duties:
1. completes or arranges for necessary assessments to identify a member's needs;
2. has overall responsibility for the development and updating of the Individual Plan of Care;
3. describes service options in sufficient detail to assure that the service member, or parent or guardian if applicable, is able to make an informed choice regarding self-directed and agency services; Case Management for self-direction and regular case management are encompassed in this service.
4. coordinates and monitors services to determine effectiveness in meeting the needs of the member;
5. has the authority to implement approved services prescribed in the Plan and to access emergency or crisis services as defined by policy;
6. assists members in tranitioning from another HCBS waiver; and
7. documents findings in the clinical record.

Case Management providers shall also provide information and assistance in support of member-directed services. Case managers are responsible for informing members of the opportunity to self-direct services. In

addition, the Case Managers make an initial determination of member ability to meet criteria for participation of self-directed services.

Providers of HCBS for the member, or those who have an interest in or are employed by a provider of HCBS for the member must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service are prior authorized in accordance with service plan.

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Case Management Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
• Qualified Provider Certification
• Completion of curriculum requirements for a baccalaureate degree and one year paid professional experience with aging and/or disabled populations or programs as a Case Manager, a Rehabilitation Specialist or Health Specialist and/or Social Services coordinator; or completion of degree program as a registered nurse or licensed practical nurse and one year paid professional experience.
Training Requirements: All case managers must successfully complete Case Manager Training offered or approved by OHCA. This training also incorporates identification of members who meet criteria for self-directed services, supports and education to be furnished to assist members who may choose to self-direct, assisting the member with modification of the service plan to incorporate self-directed services, supporting the member in a transition to self-direction or from self-direction to the use of agency services. The training informs the case manager about how to assist the member with establishing a budget and reviewing reports of services authorized and used. In addition, the Case Managers are trained on how to assess the member's satisfaction with self-directed services on an ongoing basis.
Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

Personal care services under the State plan differ in service definition from the services offered under the waiver including provider training requirements and qualifications. Members served under the waiver have a higher level of care need than those individuals served under State plan personal care. Waiver members have to meet skilled nursing facility or hospital level of care. The scope, nature and provider type including waiver certification require more quality planning and action by agencies delivering waiver personal care. This is not required for State Plan Personal Care service agencies. State Plan Personal Care is afforded to individuals with lower level of care needs than in this waiver.

Supervision of personal care providers will be furnished by a registered nurse, licensed to practice nursing in the State or by a licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law or by the participant-employer of the personal care provider. This level of care is necessary because of

the many direct, hands on care services to be furnished by Personal Care Assistants. This nursing supervision is billed as a skilled nursing waiver service. Frequency or intensity of supervision is determined by the service plan, and will be no less often than every 6 months. Duties of the Supervisor will include the following:

Utilize the plan of care to determine the training needs of the personal care assistant for each Member assigned and implement the plan of care that meets the needs of each Member.
Monitor the provision of Personal Care services and authorized RN visits to ensure that services are delivered in accordance with the services authorized in the Members service plan.
Complete a written evaluation of each Personal Care Assistants performance at least annually.
Communicate with the Case Manager regarding changes in any Members condition and recommended changes in scope or frequency of services delivery.
Report any PCA suspected of abuse, neglect or exploitation to the Adult Protective Services staff of the Oklahoma Department of Human Services, the Attorney General Medicaid Unit and the Oklahoma State Department of Health.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service are prior authorized in accordance with service plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Care Assistant
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Individual
Provider Type:
Personal Care Assistant
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
• Qualified Provider Certification
• The PCA is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, name does not appear on the DHS Community Services Workers Registry.
• Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history

and/or personal references, has verifiable identification.
Training Requirements: Demonstrates competency to a qualified evaluator to meet the personal care assistance needs of the individual member.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency
Provider Type:
Home Care Agency
Provider Qualifications

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

Other Standard *(specify):*
• Qualified Provider Certification
• The PCA is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, name does not appear on the DHS Community Services Workers Registry.
• Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification.
Training Requirements: Demonstrates competency to a qualified evaluator to meet the personal care assistance needs of the individual member.

Nurse Supervision Requirements:
Registered nurse (RN) supervision of Personal Care services is a state requirement of the Medicaid Program. Each Medicaid provider agency must have an RN available to perform specific supervisory functions unless the plan of care includes only homemaker chore tasks. If the plan contains homemaker chores only, the agency may designate the qualifications of the supervisor. While some of the nursing supervision functions may be delegated to a licensed practical nurse (LPN), as described below, the provider agency is still responsible for having registered nurse staff available to perform specified supervisory tasks.
At a minimum the provider agency must meet services quality monitoring and oversight requirements in accordance with OAC 310: 662-5-4. As part of the certification as a qualified provider of Home Care services, agencies are required to develop and implement a Continuous Quality Improvement (CQI) plan that details the quality safeguards the provider has designed to meet the state requirements. The provider will be held accountable for following the Quality Self-Audit process for supervisory oversight of personal care services described in the individual provider's OHCA approved CQI plan. For Quality Self-Audit supervisory monitoring visits, the RN shall visit the member at home or determine that an LPN make the visit based upon the types of Personal Care services authorized in the member's plan of care.

The RN has the responsibility of determining the status of the present plan of care in meeting the member's needs. The LPN is under the direct supervision of the RN. This supervision includes a review and co-signature by the RN for all reports prepared by the LPN and consultation between RN and LPN as needed.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:
Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. The cost of room and board will not be covered except when provided as part of respite care in a facility approved by the State that is not a private residence. Respite care is provided in the following:
Individual's home or place of residence
Nursing Facility

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Facility
Individual	Personal Care Assistant - Respite
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Nursing Facility
Provider Qualifications
License *(specify):*
Nursing Facility
63 O.S., Sec. 1-1901, et seq.
Certificate *(specify):*

Other Standard *(specify):*
Qualified Provider Certification
Medicaid Provider Agreement
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to Enrollment and 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:
Personal Care Assistant - Respite
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
• Qualified Provider Certification
• The PCA is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-

1950 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, name does not appear on the DHS Community Services Workers Registry.
Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification.
Supervision of the individual is conducted by the participant-employer of the personal care provider. The participant-employer supervises the provider each time the personal care provider renders services.
Training Requirements: Demonstrates competency to a qualified evaluator to meet the personal care assistance needs of the individual member.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and 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:
Home Care Agency
Provider Qualifications

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

Other Standard *(specify):*
• Qualified Provider Certification
• Respite provider is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, name does not appear on the DHS Community Services Workers Registry.
Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Prescribed Drugs

HCBS Taxonomy:

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

Service Definition *(Scope):*
Prescribed drugs available through the approved State plan will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. The State Plan prescribed drug benefits for waiver members include both brand and generic medications. Brand name drugs where no generic equivalent is available must be prior authorized. Prior authorization is also required on generic drugs in excess of State Plan and Extended State Plan benefits.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Exceptions to State Plan prescribed drug benefits with respect to amount, frequency and duration of service require a prior authorization. Prescribed drugs available under Medicare Part D will not be provided under the provisions of this Waiver to Waiver members who are dual (Medicare/Medicaid) eligible. Extended State Plan prescribed drugs provided under the provisions of this Waiver are in addition to the State Plan Prescribed Drugs benefit. The member's pharmacy may submit a written request on behalf of the member to have additional prescription needs reviewed. In addition to making a determination of a medical necessity for the additional prescription product(s) being requested, this review to be performed by the OU College of Pharmacy could result in a recommendation that certain medication regimens be altered or discontinued. Recipient co-payments will be required for each monthly prescribed drug. There is no co-payment for preferred generic medications. Co-payment amounts are as described in the State Plan.

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

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pharmacy

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Pharmacy
Provider Qualifications
License *(specify):*
Pharmacy
59 O.S., Sec., 353.9 et seq.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

Service Definition *(Scope):*
Advanced Supportive/Restorative Care services are maintenance services provided to assist a member with a

stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function. The Advanced Supportive/Restorative Assistance Aide does not perform any nurse functions.

Advanced Supportive/Restorative Care is a maintenance service and should never be used as a therapeutic treatment. Recipients who develop medical complications requiring skilled nursing services while receiving Advanced Supportive/Restorative Care services should be referred to their attending physician, who may, if appropriate, order home health services.

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

Routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies with well-healed stoma) and external, indwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;
Remove external catheters, inspect skin and reapplication of same;
Use lift for transfers; Manually assist with oral medications which are set up by a registered or licensed practical nurse;
Provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;
Apply non-sterile dressings to superficial skin breaks or abrasions as directed by a registered or licensed practical nurse; and
Use Universal precautions as defined by the Center for Disease Control.

The OHCA Care Management Team in reviewing service plan requests for Advanced Supportive/Resorative Assistance will not give approval if State Plan Personal Care benefits could be used instead. In addition, the Care Management Team will ensure that duplicative services are not authorized and that AS/RA aides do not perform any functions performed by a nurse.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service is prior authorized in accordance with service plan.

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency
Individual	Advanced Supportive/Restorative Aide

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Home Care Agency
Provider Qualifications
License *(specify):*
Home Care License

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

Other Standard *(specify):*
• Qualified Provider Certification
• The ASR Assistant is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, name does not appear on the OKDHS Community Services Workers Registry.
• Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification.

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

The agency must provide Advanced Supportive/Restorative Assistance training specific to the care needs of the members receiving Advanced Supportive/Restorative Assistance. The provider shall have written plans of the training; such training must include at a minimum the following topics:

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

The agency must document the dates and hours of Advanced Supportive/Restorative Assistance training received by the Personal Care aide in the aide's personnel file.

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

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

The Advanced Supportive/Restorative Assistance agency shall have written documentation of all basic and in-service training provided which includes, at a minimum, a report of each employee's training in that employee's personnel record. The report shall document the dates of all classroom or individualized training, trainer's name, topics, number of hours, and location; the date of first unsupervised service delivery; and shall contain the worker's signature. If an agency waives the in-service training, the employee's training record shall contain supportive data for the waiver of training.

Nurse Supervision Requirements:

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

The registered nurse must:
• Conduct an initial assessment visit and develop the plan of care for members with Advanced Supportive/Restorative Care needs, in collaboration with the case manager.

• Conduct on-site visits to all Advanced Supportive/Restorative Care members at six-month intervals. During the visit, the RN shall conduct an evaluation of the adequacy of the authorized services to meet the needs and conditions of the member, and shall assess the Advanced Supportive/Restorative Care Aides' ability to carry out the authorized services. Additional hours may be authorized for on-site nurse visits if the waiver participant needs additional visits.

• Make periodic member evaluations, on a schedule as prescribed by the service plan and paid for by the waiver. Evaluation reports shall be made available to the case manager within 48 hours of each evaluation. Frequency of nurse supervision visits at a minimum is every six months with additional visits specified in the service plan. Nurse supervision visits will generally not exceed one per month.

• Conduct annual assessment/reassessment visits and develop the plan of care for all subsequent years for members with Advanced Supportive/Restorative Care needs, in collaboration with the case manager.

• Attend IDT meetings to establish or amend the Service Plan.

• Be available, at least by telephone, during any period of time Advanced Supportive/Restorative Care is being provided.

• Observe the successful execution by the aide of each Advanced Supportive/ Restorative Care task during a member-specific training session, and certify the successful completion of the task in the aide's personnel record. This visit may be authorized and reimbursed as a skilled nursing service.

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

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Advanced Supportive/Restorative Aide

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
• Qualified Provider Certification
• Medicaid Provider Contract

• The ASR Assistant is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, name does not appear on the OKDHS Community Services Workers Registry.
• Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification.

Training Requirements: It should be noted that Advanced Supportive/Restorative aides do not perform any functions that typically would be performed by a nurse. All Advanced Supportive/Restorative Assistance aides are required to receive the same basic Personal Care training as a Personal Care aide, and also must be given the following training prior to delivery of Advanced Supportive/ Restorative Assistance services:

• Prior to performing any Advanced Supportive/Restorative Assistance task for any member for the first time, the AS/RA aide must demonstrate competency in the tasks in a member-specific training session conducted by the member. The member will provide guidance on the tasks to be performed and will also state any preference for service delivery. The member must document the attendant's competency in performing each task in the AS/RA's personnel file. In addition, Waiver Skilled Nursing services are authorized to provide assistance with training of the AS/RA aide and/or to provide skilled nursing oversight monitoring for the delivery of AS/RA services. A nurse is required to observe the successful execution by the AS/RA aide of each Advanced Supportive/Restorative Assistance task during a member-specific training session, and certify the successful completion of the task in the AS/RA aide's personnel record.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

Service Definition *(Scope):*
Those architectural and environmental modifications and adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home. Such modifications and adaptations may include the installation of ramps, lifts, grab-bars, widening of doorways, modification of bathroom or kitchen facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Specialized safety adaptations include scald protection devices, stove guards, installation of specialized equipment used by people who have vision or hearing impairments or behavioral challenges. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. Modifications will not be made to homes owned or leased by waiver service providers.

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

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

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Architect; Electricians; Engineers; Mechanical Contractors; Plumbers; Re-modelers and Builders

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual

Provider Type:
Architect; Electricians; Engineers; Mechanical Contractors; Plumbers; Re-modelers and Builders

Provider Qualifications

License *(specify):*
Architects Oklahoma Administrative Code Title 55, Chapter; Electricians Licensing Act, 59 O.S., et seq.;Mechanical Licensing Act, 59 O.S., Sec. 1850.1-1850.15; Plumbing Licensing Act, 59 O.S., Sed. 1001-1021; Appropriate licenses from the Oklahoma Department of Health Construction Industries Board.

Certificate *(specify):*

Other Standard *(specify):*

• Qualified Provider Certification
• ADA Accessibility Guidelines- 28 CFR Part 36 Appendix A.

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Home Delivered Meals

HCBS Taxonomy:

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

Service Definition *(Scope)*:
Home-delivered Meal services provide meals, each with a nutritional content equal to one-third of the Recommended Daily Allowance delivered to the home for members who are unable to prepare meals and who lack an informal provider to do meal preparation. Provision of Home-delivered Meals reduces the need for reliance on paid staff during some mealtimes by providing meals in a cost-effective manner.

Home-delivered Meals shall be included in the individual service plan only when it is necessary to prevent the institutionalization of an individual.

The goals of Home-Delivered Meals
(1) To facilitate member independence by allowing members the choice to remain in their own homes rather than enter a nursing facility.
(2) To provide one daily nutritious meal to persons at risk of being institutionalized.
(3) To provide a daily social contact to ensure the member's safety and well being.

In order to receive Home-delivered Meals under the waiver, a member must:
(1) Be unable to prepare some or all of his/her own meals, or require a special diet and be unable to prepare meals; or

Have no other individual available to prepare member's meals, or the provision of a Home-delivered Meal is the most cost-effective method of ensuring a nutritionally adequate meal.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service is prior authorized in accordance with service plan; however, one (1) meal is the maximum number of meals allowed per day.

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Delivered Meals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:
Home Delivered Meals
Provider Qualifications
License *(specify)*:
Oklahoma Health Code, Food Preparers/Handlers License – Sec., 1110 & 1119
59 O.S. Sec., 21
Certificate *(specify)*:
County Health Department Kitchen and Food Handler Certification
Other Standard *(specify)*:
• Qualified Provider Certification
• Title III Program Home-Delivered Meal Provider Standards
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to Enrollment and Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Title:
Hospice Care

HCBS Taxonomy:

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

Service Definition *(Scope):*
Hospice Care: Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six (6) months or less to live and orders Hospice Care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the members illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the members medical care for the terminal illness in the home environment. The team may include physicians, nurses, counselors, social workers, aides, volunteers, chaplains and others.

A Hospice plan of care must be developed by the hospice team in conjunction with the members case manager before hospice services are provided. The hospice plan of care is a separate document from the Medically Fragile Service Plan. However, the hospice plan of care and Medically Fragile Service Plan are coordinated to compliment each other like a hand and a glove. The hospice services must be related to the palliation or management of the members terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Without duplicating waiver services, hospice services may include nursing and personal care, social worker services, grief and loss counseling for the member and the family as individually determined for each member who receives hospice services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service is prior authorized in accordance with service plan.

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Facility
Agency	Hospice Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Hospice Care

Provider Category:
Agency
Provider Type:
Nursing Facility
Provider Qualifications
License *(specify):*
63 O.S. 1991 seq, Section 1-860 et seq
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Hospice Care

Provider Category:
Agency
Provider Type:
Hospice Agency
Provider Qualifications
License *(specify):*
63 O.S., 1991, Sec., 1-860 et seq.
Certificate *(specify):*
Medicare Hospice Certification
Other Standard *(specify):*
• Qualified Provider Certification
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Institutional Transition Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Institutional Transition Services are those services that are necessary to enable individuals to leave the institution and receive waiver services in their home and/or in the community.

Institutional Transition Services may include:

. Case Management

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

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

The individual is eligible to receive waiver services outside the institutional setting;

Institutional Transition Services are provided to the member within 180 days of discharge from the institution;

Transition Services provided while the member is in the institution are to be claimed as delivered on the day of discharge from the institution.

Case Management Services:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Institutional Transition Services

Provider Category:
Agency

Provider Type:
Case Management

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Same as Case Management

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA

Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

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

Service Definition *(Scope)*:
PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

The service is authorized by the members Service Plan and is necessary to prevent institutionalization. This service includes both the unit and the monitoring.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service is prior authorized in accordance with service plan.

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

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

Specify whether the service may be provided by *(check each that applies)*:
- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment Supplier

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:
Agency
Provider Type:

Durable Medical Equipment Supplier

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Qualified Provider Certification for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies found at OAC 317:30-5-210., Eligible providers

Verification of Provider Qualifications

Entity Responsible for Verification:

OHCA Provider Enrollment Unit

Frequency of Verification:

Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Private Duty Nursing

HCBS Taxonomy:

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

Service Definition *(Scope):*

Private Duty Nursing is individual and continuous skilled nursing care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to the member at home. The provision of this service will prevent institutionalization of the member.

There are no service limts, but the need for private duty nursing must be documented in the member assessment before OHCA will authorize this in the member's service plan.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Duty Nursing

Provider Category:
Agency

Provider Type:
Home Care Agency

Provider Qualifications

License *(specify)*:
Registered Nurse; Licensed Practical Nurse; Licensed under the Nurse Practice Act – 59 O.S., Sec., 567.1-567.16
Employed by a Home Care Agency
63 O.S., Sec., 1-1961, et seq.

Certificate *(specify)*:

Other Standard *(specify)*:
• Qualified Provider Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider Enrollment Unit

Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the 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:**
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not duplicate othere 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 outcomes 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:
This service has no limits on the amount, frequency, or duration of service.

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **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. For example, a vendor could be the local newspaper for advertising for possible employees to provide self-direction.

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. For example, a vendor could be the local newspaper for advertising for possible employees to provide self-direction.

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 / Comfirmed by Fiscal Management Services (FMS).

Frequency of Verification:
Upon purchase and annually at planning meeting.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Skilled Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope)*:
Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. The provision of this service will prevent institutionalization of the member.

The nursing services which may be authorized are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended as treatment for an acute health condition and may not include services, which would be reimbursable as skilled nursing care under either the Medicare or Medicaid Home Health Programs. Should the Personal Care nurse detect a need for services that would meet the definition of reimbursable skilled nursing care under the Home Health Program, he/she must alert the members primary care provider or Case Manager and the waiver program staff.

Skilled nursing services may include one or more of the following, where appropriate to meet the needs of the member as authorized by the waiver program:

Filling a one-week supply of insulin syringes for a blind diabetic who can self-inject the medication but cannot fill his own syringe. This service would include monitoring the patient's continued ability to self-administer the insulin;
Setting up oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level or disorientation or confusion;
Monitoring a member's skin condition when a member is at risk of skin breakdown due to immobility or incontinence or the member has a chronic stage II decubitis requiring maintenance care and monitoring;
Conducting general health evaluations;
Providing nail care for the diabetic member or member with circulatory or neurological deficiency;
Making an on-site visit to each member for whom Personal Care or Advanced Supportive/Restorative Care services are authorized to evaluate the condition of the member. A visit report will be made to the case manager, to report the member's condition or other significant information concerning each Personal Care or Advanced Supportive/Restorative Care member; frequency of these nurse supervisory visits is determined by the individual service plan and will occur no less often than every 6 months; and
Provide member specific training and competency testing for Advanced Supportive/Restorative Assistants.
Provide to the case manager a copy of each Nursing Evaluation (within 24 hours) or monitoring visit (within 48 hours) paid for by the waiver.

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

It is the responsibility of the RN to contact the member's physician to obtain any necessary information or orders pertaining to the care of the member. If the member has an ongoing need for service activities, which require more or less units than authorized, the RN shall recommend, in writing, that the Plan of Care be revised.

A member who is approved for skilled nursing may not in addition receive private duty nursing. Before authorizing the member service plan, the OHCA Care Management Team will review member claim data to ensure that the member has first utilized all State Plan health benefits and that no duplication of services occurs.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service is prior authorized in accordance with service plan.

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [x] **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Agency

Provider Type:
Home Care Agency

Provider Qualifications

License *(specify):*
Registered Nurse; Licensed Practical Nurse; Licensed under the Nurse Practice Act – 59 O.S., Sec., 567.1-567.16
Employed by a Home Care Agency
63 O.S., Sec., 1-1961, et seq.

Certificate *(specify):*

Other Standard *(specify):*
• Qualified Provider Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider enrollment unit

Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies

Category 2:	Sub-Category 2:

14 Equipment, Technology, and Modifications	14031 equipment and technology

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

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

Service Definition *(Scope):*
Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non durable medical equipment not available under the Medicaid State plan.

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

Personalized emergency response systems may not be billed as specialized medical equipment and supplies.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service is prior authorized in accordance with service plan.

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Medical and Rehabilitative Equipment Manufacturers and Suppliers
Provider Qualifications
License *(specify):*
Oklahoma Medicaal Practice Act 59 O.S. Sec., 481-536
Certificate *(specify):*

Other Standard *(specify):*
- Qualified Provider Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider Enrollment Unit

Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Therapy Services: Respiratory

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11110 respitory therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Respiratory Therapy Services

Respiratory therapy services are provided for an individual who, but for the availability of in-home respiratory care services, would require respiratory care as an inpatient in a hospital or NF and would be eligible to have payment made for inpatient care under the State plan.

An individual who receives home respiratory care must receive these services under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member.

Respiratory Therapy Service Components:

1. Evaluation

Visit made to evaluate the members level of function and to determine whether respiratory therapy is reasonable

and necessary and to establish, in consultation with the members physician, the goals, treatment plan, and estimated frequency and duration of treatment.

2. Respiratory Treatments

Providing respiratory therapy in accordance with the plan of treatment, including instruction of the member, family or other caregivers regarding use of respiratory equipment, supplies and techniques.

3. Chest Physiotherapy

Chest physiotherapy (postural drainage, chest percussion and vibration, pulmonary exercises) is a skilled service and would be considered covered if a cardio-pulmonary condition is present.

4. Maintenance Therapy Program

Repetitive services required to maintain function and prevent regression do not usually require the skills of a therapist.

A maintenance program may be established if, after an evaluation, the restorative potential of the member is judged to be insignificant. In such situations, the evaluation, the instruction of the member or caregivers, and reevaluations until the program can be safely and effectively carried out are all considered to be covered therapy services.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency
Individual	Respiratory Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapy Services: Respiratory

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

Other Standard *(specify):*

• Qualified Provider Certification
• The agencies must employ state-licensed respiratory therapist

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider Enrollment Unit

Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapy Services: Respiratory

Provider Category:
Individual

Provider Type:
Respiratory Therapist

Provider Qualifications

License *(specify):*
59 O.S. Sec. 2026, et seq.

Certificate *(specify):*

Other Standard *(specify):*
• Qualified Provider Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider Enrollment Unit

Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Therapy Services: Occupational

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
Occupational Therapy Services

The services of an occupational therapist are necessary to assess the beneficiary's needs, to develop goals (to be approved by the physician), to manufacture or adapt the needed equipment to the beneficiary's use, to teach compensatory techniques, to strengthen the beneficiary as necessary to permit use of compensatory techniques, and to provide activities which are directed toward meeting the goals governing increased perceptual and cognitive function. Occupational therapy services are covered at a duration and intensity appropriate to the severity of the impairment and the beneficiary's response to treatment.
A member's recovery and safety can be affected by perceptual and cognitive deficits. Deficits which impact the functional ADL, mobility, and/or safety of the beneficiary and necessitate skilled intervention must be documented.
The planning, implementing, and supervision of therapeutic programs, including but not limited to those listed below, are occupational therapy services if reasonable and necessary to the treatment of the beneficiary's illness or injury.
a.Selecting and teaching task-oriented therapeutic activities designed to restore physical function.
b.Planning, implementing, and supervising therapeutic tasks and activities designed to restore sensory-integrative function.
c.Teaching compensatory techniques to improve the level of independence in the activities of daily living.
d.The designing, fabricating, and fitting of orthotic and self-help devices.
Vocational and prevocational assessment and training which are directed toward the restoration of function in the activities of daily living lost due to illness or injury. When vocational or prevocational assessment and training are related solely to specific employment opportunities, work skills or work settings such services would not be covered because they would not be directed toward the treatment of an illness or injury.
Occupational Therapy Service Components:
1.Evaluation
Visit made to determine occupational therapy needs of the member at the home. Includes physical and psychosocial testing, establishment of plan of treatment, rehabilitation goals, and evaluating the home environment for accessibility and safety and recommending modifications.
2.Independent Living/Daily Living Skills (ADL) Training
Refers to the skills and performance of physical cognitive and psychological/emotional self care, work, and play/leisure activities to a level of independence appropriate to age, life-space, and disability and includes instruction of the member, family or other caregivers regarding training techniques.
3.Muscle Re-education
Includes therapy designed to restore function lost due to disease or surgical intervention.
4.Perceptual Motor Training
Refers to enhancing skills necessary to interpret sensory information so that the individual can interact normally with the environment. Training designed to enhance perceptual motor function usually involves activities which stimulate visual and kinesthetic channels to increase awareness of the body and its movement.
5.Fine Motor Coordination
Refers to enhancing the skills and performance in fine motor and dexterity activities.
6.Neurodevelopment Treatment
Refers to enhancing the skills and the performance of movement through eliciting and/or inhibiting stereotyped, patterned, and/or involuntary responses which are coordinated at sub-cortical and cortical levels.
7.Sensory Treatment
Refers to enhancing the skills and performance in perceiving and differentiating external and internal stimuli such as tactile awareness, stereognosis, kinesthesia, proprioceptive awareness, ocular control, vestibular awareness, auditory awareness, gustatory awareness, and olfactory awareness necessary to increase function.
8.Orthotics/Splinting
Refers to the provision of dynamic and static splints, braces, and slings for relieving pain, maintaining joint alignment, protecting joint integrity, improving function, and/or decreasing deformity. These splints, braces and slings are provided by a manufacturer.
9.Adaptive Equipment (fabrication and training)

Refers to the provision of special devices that increase independent functions. The OT skills are needed for the designing, fabricating, and fitting of adaptive equipment. Adaptive equipment that is created as a result of occupational therapy consultation is paid for under the adaptive equipment benefit.
10. Maintenance Therapy Program
Repetitive services required to maintain function and prevent regression do not usually require the skills of an occupational therapist.

A maintenance program may be established if, after an evaluation, the restorative potential of the member is judged to be insignificant. In such situations, the evaluation, the instruction of the member or caregivers, and reevaluations until the program can be safely and effectively carried out are all considered to be covered therapy services.
The OHCA Care Management Team will review service plans to ensure that duplication of services does not occur.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service is prior authorized in accordance with service plan.

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapy Services: Occupational

Provider Category:
Individual
Provider Type:
Occupational Therapist
Provider Qualifications
License *(specify):*
59 O.S., Sec., 888.1 et seq.
Certificate *(specify):*

Other Standard *(specify):*
• Qualified Provider Certification
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapy Services: Occupational

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

Other Standard *(specify):*
• Qualified Provider Certification
• Provider agencies are required to employ state licensed occupational therapists
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCA Provider enrollment unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

Service Definition *(Scope):*
Physical Therapy Services

Physical Therapy services prevent physical disability through the evaluation and rehabilitation of individuals disabled by pain, disease or injury. Services are intended to help the Member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as: massage, manipulation, therapeutic exercise, cold heat, hydrotherapy, electrical stimulation and light. Under a physician's order, a licensed physical therapist evaluates the recipient's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for caregivers to assist with and/or maintain services, where appropriate.

1.Assessment Visits by a physical therapist to assess a member's rehabilitation needs and potential or to develop and/or implement a physical therapy home program. Assessment should include objective tests and measurements such as, but not limited to, range of motion, strength, balance, coordination, endurance, or functional ability. Visits for management of the physical therapy service in the member's service plan should also be included as assessment visits as these determinations rely upon the skills and expertise of a licensed physical therapist.
2.Therapeutic Exercises Therapeutic exercise which, due either to the type of exercise or the condition of the member, must be performed by or under the supervision of a physical therapist to ensure the member's safety and the effectiveness of the treatment.
3.Gait Training. Gait evaluation and training are covered when reasonable and necessary for a member whose ability to walk has been impaired by neurological, muscular, or skeletal abnormalities if they can be expected to improve materially the member's ability to walk.
4.Range of Motion. Only a qualified therapist may perform range of motion tests and therefore such tests are skilled physical therapy. Range of motion exercises are covered only if they are part of the active treatment for a specific disease state, illness or injury which has resulted in a loss or restriction of mobility. Physical therapy notes should document the degree of motion lost and the degree to be restored.
Range of motion exercises that are not related to the restoration of a specific loss of function may usually be provided safely and effectively by a non-skilled individual.
5.Maintenance Therapy Program
Repetitive services required to maintain function and prevent regression do not usually require the skills of a physical therapist.
A maintenance program may be established if, after an evaluation, the restorative potential of the member is judged to be insignificant.In such situations, the evaluation, the instruction of the member or caregivers, and reevaluations until the program can be safely and effectively carried out are all considered to be covered therapy services.
The OHCA Care Management Team will review service plans to ensure that duplication of services does not occur.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service is prior authorized in accordance with service plan.

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapy Services: Physical

Provider Category:
Individual
Provider Type:
Physical Therapist
Provider Qualifications
License *(specify):*
59 O.S., Sec., 887.1 et seq.
Certificate *(specify):*

Other Standard *(specify):*
• Qualified Provider Certification
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapy Services: Physical

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

Other Standard *(specify):*
• Qualified Provider Certification
• Provider agencies must employ state licensed physical therapists
Verification of Provider Qualifications
Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Title:
Therapy Services: Speech

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Speech and Language Therapy Services

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

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

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

The services of a speech-language pathologist to establish a hierarchy of speech-voice-language communication tasks and cueing that directs a beneficiary toward speech-language communication goals in the plan of treatment would be a covered speech-language pathology service. The services of a speech-language pathologist to train the beneficiary, family, or other caregivers to augment the speech-language communication, treatment, or to establish an effective maintenance program would be covered speech therapy. The services of a speech-language pathologist to assist beneficiaries with aphasia in rehabilitation of speech and language skills are covered when needed by a beneficiary. The services of a speech therapist to assist individuals with voice disorders to develop proper control of the vocal and respiratory systems for current voice production are covered when needed by a beneficiary.

Speech and Language Therapy Service Components:
1.Evaluation
Visit made to determine the type, severity and prognosis of communication disorder, whether speech therapy is reasonable and necessary and to establish the goals, treatment plan, and estimated frequency and duration of treatment.
2.Voice Disorders Treatments
Procedures and treatment for members with an absence or impairment of voice caused by neurologic impairment, structural abnormality, or surgical procedures affecting the muscles of voice production.
3.Speech Articulation Disorders Treatments
Procedures and treatment for members with impaired intelligibility (clarity) of speech - usually referred to as

anarthria or dysarthria and/or impaired ability to initiate, inhibit, and/or sequence speech sound muscle movements - usually referred to as apraxia/dyspraxia.
4.Dysphagia Treatments
Includes procedures designed to facilitate and restore a functional swallow when associated with a communication disorder.
5.Language Disorders Treatments
Includes procedures and treatment for members with receptive and/or expressive aphasia/dysphasia, impaired reading comprehension, written language expression, and/or arithmetical processes.
6.Aural Rehabilitation
Procedures and treatment for members with communication problems related to impaired hearing acuity.
7.Maintenance Therapy Program
Repetitive services required to maintain function and prevent regression do not usually require the skills of a therapist.

A maintenance program may be established if, after an evaluation, the restorative potential of the member is judged to be insignificant. In such situations, the evaluation, the instruction of the member or caregivers, and reevaluations until the program can be safely and effectively carried out are all considered to be covered therapy services.
Members who receive speech therapy services while in an Adult Day Health setting may not receive therapy services in the same day. The OHCA Care Management Team will review service plans to ensure that duplication of services does not occur.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Amount, frequency and duration of service is prior authorized in accordance with service plan.

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agency
Individual	Speech Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapy Services: Speech

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

Other Standard *(specify):*
• Qualified Provider Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapy Services: Speech

Provider Category:
Individual
Provider Type:
Speech Therapist
Provider Qualifications

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

Other Standard *(specify):*
• Qualified Provider Certification

Verification of Provider Qualifications

Entity Responsible for Verification:
OHCA Provider Enrollment Unit
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

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

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

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

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

Proof of OSBI background check must be documented in the provider personnel record as maintained by the provider agency or the fiscal management service (FMS). The Oklahoma Department of Health evaluates documentation of OSBI background check prior to hire as a standard component of license review inspections of Home Care Agencies and Adult Day Health Centers. Before a provider agency can be certified to provide services for the Waiver the provider agency must document its procedures to ensure that OSBI background checks are performed prior to hiring. A member who is self-directing services must have proof that a personal care worker passes this required background check. Both the member and the FMS maintain proof of criminal background checks. In addition, OHCA conducts provider audits to monitor that these checks are performed.

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

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

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

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

In addition, in accordance with Title 56, of Oklahoma Statutes, Section 1025.2, a provider of direct care services whose name appears on the Community Services Worker Registry maintained by the Oklahoma Department of Human Services may not provide services to members in this waiver. Proof of both Nurse Aide Registry and Community Services Worker Registry checks must be documented in the provider personnel record. The Oklahoma Department of Health evaluates documentation of the Nurse Aide Registry checks prior to hire as a standard component of license review inspections of Home Care Agencies and Adult Day Care Centers. Before a provider can be certified for the Medically Fragile waiver program, the provider must document its procedures to ensure that Nurse Aide and Community Services Worker Registry checks are performed prior to hiring. In addition, OHCA conducts provider audits annually to monitor that these checks are performed.
The Financial Management Service Agency maintains this documentation for services which are self directed. An audit of the FMS is also performed annually to ensure that these registry screenings are conducted.

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.*

Services and Supports Provided by a Legally Responsible Individual

In accordance with OHCA rules, for a legally responsible individual (spouse or guardian) of a member to be paid for providing personal care/ or Advance Supportive/Restorative services under the 1915 (c) waiver, the service must meet all of the following authorization criteria. The OHCA Care Management team will monitor the activities to make sure all provisions have been met.

Authorization for a legally responsible individual (spouse or guardian) to be the care provider for a client's personal care/assistance service may occur only under the following conditions:

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

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

If any of the following criteria is met, personal care or advanced supportive/restorative services provided by the spouse or guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or guardian:
Spouse or guardian has resigned from full-time/part-time employment to provide care for the client, or
Spouse or guardian has reduced employment from full-time to part-time to provide care for the client, or
Spouse or guardian has taken a leave of absence without pay to provide care for the client, or
Spouse or guardian provides assistance/care for the client thirty-five or more hours per week without pay and the client has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the client.

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

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

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

Monitoring Requirements:

In addition to Case Management monitoring and reporting activities required for all waiver services, the LTCWO designated staff is responsible for performing the following monitoring requirements when a Member elects to use a legally responsible spouse or guardian as a paid service provider:
at least quarterly reviews of expenditures, and the health, safety, and welfare status of the individual recipient;
Face-to-face visits with the member on at least a semi annual basis;
Monthly reviews of hours billed for spouse or guardian provided care.

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

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

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

A relative/legal guardian may provide waiver services to members in accordance with the policies below.

Relatives/legal guardians eligible for payment for providing services under this waiver must meet the following:
1. be at least 18 years of age
2. have no pending notation related to abuse, neglect or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry,
3. is not included on the Community Services Worker Registry in accordance with section 1025.2 of Title 56, of the Oklahoma Statutes,
4. have not been convicted of a crime as outlined in Title 63 of Oklahoma Statutes, sections 1-1950 as determined by an OSBI background check,
5. demonstrates the ability to undertand and carry out assigned tasks,
6. is not a legally responsible family member (spouse or parent of a minor child)of the member being served,
7. has a verifiable work history and/or personal references, verifiable identification,
8. have no more than 40 hours of reimbursed services in a seven day period and

9. meets any additional requirements as outlined in the agreement and certification requirements with the Oklahoma Health Care Authority.

Personal Care services are intended to supplement and support existing informal care and the use of informal supports as Personal Care Attendants may jeopardize the informal support system. In this waiver the relevant issue is not whether the person being hired is to provide personal care/assistance services is a relative or not as much as whether the person being hired is already a part of the informal support system providing services informally and without compensation. Consequently, a provider agency may only employ member relatives or other persons who are currently providing services without compensation to provide personal care or similar services with the written agreement of the interdisciplinary team.
Prior to agreeing to permit employment of relatives of other persons who are already providing informal supports, the interdisciplinary team takes the following into consideration:
o The member is offered a choice of providers and documentation demonstrates that:
o Either no other provider is available; or,
o Available providers are unable to provide necessary care to the client, or
o The needs of the client are so extensive that the relative or an informal support who provides the care is prohibited from working outside the home due to the client's need for care; and
o In the team's judgement, employment of the relative/informal provider as a paid provider will not overburden the individual so employed and ultimately be destructive to maintaining member supports.

When under the aforementioned conditions, a relative or other person providing informal supports is hired to provide personal care/assistance services to a waiver participant, special forms and procedures are used by the Provider Agency Care Manager to document this occurrence including forwarding a copy of documentation forms to the OHCA/Care Management Team.

Controls employed to ensure that payments are made only for services rendered are the same that Long Term Care Waiver Operations Division applies to all providers:
- Units are authorized on the service plan consistent with tasks required to meet member needs;
- Timesheet documentation of service delivery is required of all direct care providers;
- Provider audits review documentation for compliance of delivery of services to authorization.

OHCA will only reimburse relatives/legal guardians for services, limited to no more than 40 hours in a seven day period, that meet the above criteria and that are authorized by the OHCA Care Management Team in approving the member service plan. OHCA is the state agency that performs these activities.

○ **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:

Throughout the year, any willing provider requesting to become a waiver provider is sent a packet of information about the waiver and the provider enrollment process. Upon request, potential providers are sent a provider enrollment application, copies of the provider agreements, and submission timeframes to become a waiver provider.

Based on the number of providers who express an interest, provider meetings will be held throughout the year to inform potential providers of the performance standards and guidelines required of those providing services to members in the waiver. At a minimum, a public meeting will be held annually to recruit potential new providers for the waiver. Potential providers will receive an application, copies of the provider agreement, and submission timeframes to become a waiver provider.

The certification process involves a review of general and administrative, financial, and programmatic components of the provider application to determine the potential provider's capacity and capability to provide waiver services that meet or exceed minimum standards. The certification process results in the determination of a potential provider's qualifications to become a waiver provider. These are the steps that result in "Qualified Provider Certification" referenced throughout appendix C as an "Other Standard" that must be met by waiver participating providers.

OHCA reviews completed provider applications in no less than 10 business days and forwards qualified provider documentation to Provider Enrollment to enter on the Provider File. Provider Enrollment enrolls providers in 7 to 10 working days. However, if expedited processing is requested, a provider can be enrolled in the same business day.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percentage of providers that met licensing standards and requirementrs prior to furnishing waiver services. Denominator: Number of providers performing waiver services. Numerator: Number of providers that met licensing standards and requirements prior to performing waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTCWO Provider Licensing Database

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percentage of providers that met licensing standards and requirements verified annually. Denominator: Total number of providers reviewed for licensing standards and requirements. Numerator: Total number of providers that met licensing standards and requirements annually.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTCWO Provider Licensing Database

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

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Percentage of non-certified providers who met the qualifications as specified in C-3 of this application prior to performing services. Denominator: Number of non-certified providers performing services. Numerator: Number of non-certified providers who met qualifications prior to performing services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Audit of employee files

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

Data Aggregation and Analysis:

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

☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percentage of non-licensed providers who met the qualifications as specified in C-3 of this application prior to performing services. Denominator: Number of non-licensed providers who performed waiver services. Numerator: Number of non-licensed providers who met qualifications prior to performing waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Report from Provider Audits of employee files

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

Data Aggregation and Analysis:

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

Performance Measure:
Number of non-certified providers who met qualifications as verified annually. Denominator: Total number of non-certified providers. Numerator: Number of non-certified providers who met qualifications annually.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTCWO Provider Licensing Database

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of non-licensed providers who met qualifications as verified annually. Denominator: Total number of non-licensed providers. Numerator: Total number of non-licensed providers who continually met qualifications annually.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LTCWO Provider Licensing Database

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

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Percentage of Home Health agencies who met staff training requirements prior to furnishing services in this waiver as documented in the employee's personnel file. Denominator: Number of home health agencies who met staff training requirements. Numerator: Number of home health provider agencies who met staff training prior to providing waiver services as documented in the employee's personnel file.

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

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

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
On an annual basis the OHCA, QA/QI audit team will conduct provider audits to ensure waiver compliance. Provider training will be conducted to address and make suggestions for correction of any deficiencies reported through provider audit to ensure that waiver compliance is being met.

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.
When the state detects provider non-compliance with waiver requirements, the State requires the provider to implement a corrective action plan, subject to OHCA approval. OHCA can apply both financial and administrative sanctions. The state routinely provides technical assistance during on-site reviews of provider agencies to clarify requirements and offer suggestions for performance or process improvement. A corrective action plan database is kept and letters are mailed to providers. When the provider performance improves, an exit conference review is completed and the provider is notified of a return to full compliance status. A provider that does not meet the corrective action requirements will be referred to the OHCA QA/QI committee for contract action, including contract termination.

If the State finds during a provider audit that any licensed or certified personnel have an expired license, OHCA will instruct the provider to immediately remove the personnel with the expired licenses until a renewal can be accomplished. The provider agency must also immediately address the members staffing needs to ensure that no gaps occur in servicing the member.

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

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

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design

methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

- (●) **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

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

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

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

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

- [ ] **Other Type of Limit.** The State employs another type of limit.
  Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

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

refer to Main, Attachment#2

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

  Specify qualifications:

- [ ] **Social Worker**

  Specify qualifications:

- [ ] **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

One of the foundational modules in the Case Management Training is Interdisciplinary Teams (IDT). This module is designed to educate case managers about the IDT approach to service planning and to emphasize the philosophy of seeing the "whole" person through a variety of perspectives. This module educates case managers that members, and or member representatives, are expected to be actively engaged in the initial and ongoing IDT process, service planning process and service plan monitoring process. In addition, this module presents the critical step of talking with the member before each IDT in order to identify who the member would like to invite to the team table.
Case Managers have specialized skills and competencies to perform, at minimum, five core functions. The core functions form an on-going and dynamic process. Case Management core functions are:
1. Comprehensive Assessment: Transition Coordination/Case management requires a comprehensive, systematic, standardized, and multi-dimensional assessment of the member's functional and cognitive capacity and limitations, need for services, strengths, abilities, supports and resources.
2. Planning: Planning is a resource allocation process where a service prescription is developed for a member that defines the types of services needed and the amount, frequency and duration of service delivery to meet assessed needs.
3. Implementation: Plan implementation is a process of contracting both formal and informal providers to arrange for services outlined in the plan.
4. Monitoring: "the continuing contact the Case Manager has with providers and members to ensure that services are provided in accordance with the service plan and to ascertain whether these services continue to meet the member's needs." (Schneider & Weiss, 1982)
5. Reassessment: "scheduled or event-precipitated examination of the member's situation and functioning to identify changes which occurred since the initial or most recent assessment and to measure progress toward the desired outcomes outlined in the service plan." (Schneider & Weiss, 1982)

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

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

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

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

4) Principle #4 Case Management promotes quality:
Case management promotes the quality of services provided.

5) Principle #5 Case Management is future oriented:
Case management looks into the future, predicts and makes plans based on today's indicators.

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

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

A member-centered planning approach guides the service plan development process. The Case Manager (CM) explains the process to the member and others that the member desires to participate in service planning. The case manager is responsible for training the member and the persons they designate in the process.

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

In accordance with OAC rules, case management services involve ongoing assessment, service planning and implementation, service monitoring and evaluation, member advocacy, and discharge planning.
(a) Upon receipt of a referral from the Provider Agency, the case management supervisor assigns a case manager to the member. However, the member maintains freedom of choice in selecting a provider. The case manager makes a home visit to review the waiver program (its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, Provider Agency and OHCA in the program), and review, update and complete the UCAT assessment, and to discuss service needs and service providers. The member may invite family members, personal representatives and informal support persons to be included in the service plan development. The case manager will assure that the planning meetings are scheduled at times and locations convenient to the member and his or her representative. Within ten (10) working days of the receipt of the referral, or at least ten (10) working days prior to the end-date of an existing service plan, the case management provider completes and submits to the OHCA an individualized service plan for the member.

(b) The service plan is based on the member's service needs identified by the UCAT, Part III. The case manager uses an interdisciplinary team (IDT) planning approach for service plan development. The services needed by the

member are part of the waiver benefits and are prior authorized by OHCA upon service plan approval. Any additional services needed are supplied through State Plan, other Title XIX and community resources. The member or the member's guardian and the case manager could comprise a minimum IDT. The case manager is responsible for securing information about participant's needs, preferences, goals and health status.

(c) The Case Manager provides information on all qualified providers for each service needed and assists the individual in making an informed choice of provider. In addition, the Case Manager educates the member and provides advocacy support to the member in development of service delivery to meet member individual preference for when services are delivered and the manner in which services are delivered.

(d) The Case Manager records the member's long-term goals, challenges to meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The case manager is responsible for ensuring that the service plan addresses the member's goals, needs (including health care needs), and preferences. Through the member-centered planning process, the case manager identifies services, member's choice of service provider, and submits a service plan to the member for signature. The next step in the plan development process is that the case manager submits the signed service plan to the case management supervisor for review. The case management supervisor documents the review/approval of the plans or returns the plans to the case manager with notations of errors, problems, and/or concerns to be addressed. The case manager re-submits the corrected service plan to the member and then to the case management supervisor. The case management supervisor returns the approved service plan to the case manager who faxes the plan to the OHCA Care Management Team and files the plan in the member's file.

(e) Waiver and other services are authorized by the OHCA Care Management Team. The Care Management Team reviews and, if appropriate, approves the service plan and enters the member's plan into ATLANTES. The program director exercises final decision-making authority over all service plans. The team transmits a copy of the computer-generated authorized service plan to the case manager and transmits to each of the other providers, authorized by the plan to provide services to the member. Upon receipt of service plan authorization, the case manager communicates with the service plan providers and with the member to facilitate service plan implementation. Within five (5) working days of notification of an initial or new service plan authorization, the case manager visits the member, gives the member a copy of the service plan or a computer-generated copy of the service plan and evaluates the progress of the service plan implementation.

(f) Both the case management agency and the OHCA Care Management Team have assigned responsibilities to implement and monitor the plan. As discussed above the agency providing case management is responsible for service plan development and communication with the member. Further, the OHCA Care Management Team has a role in evaluating the appropriateness of the service plan. Finally, the Long Term Care Waiver Operations (LTCWO) division will monitor periodic reports regarding services authorized and used, costs of waiver services and member complaints and inquiries.

(g) The Case Manager evaluates service plan implementation and considers any necessary updates on the following minimum schedule:
(1) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and
(2) monthly after the initial 30 day follow-up evaluation date.

Change in member needs. A member or family member may become aware of a change in member needs and may initiate a request for a change in the service plan by contacting the case manager. The case manager will complete the following:

The service provider initiates the process for an increase or decrease in service to the member's service plan. The requested changes by provider, case manager or member and justification for them are documented as a service plan amendment by the member's case manager. The case manager submits the amended service plan to the OHCA Care Management Team. The team approves or denies the amended service plans within two working days of receipt of the plan. Members whose service plan amendments are denied are notified by written letter within two working days of the denial and may appeal this decision by completing the LD-1 form and forwarding it to the OHCA Legal Division. During the appeals process, the member will continue to receive services until a final decision has been rendered. If the appealed decision is not in the member's favor, the case manager will assist with obtaining other community resources.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

OHCA conducts case management training for all case managers and provides basic knowledge and tools to enable case managers to assess appropriately and develop Service Plans which adequately address issues of risk and risk mitigation.

Contact information for each case manager, emergency, non-emergency, utilities, transportation, landlord, etc..., will be provided to the member. OHCA staff will work with the member to ensure that he/she understands the process of using each.

OHCA staff and case managers will work with the member and provider to ensure that an effective back-up plan is in place. Such back-up plans may utilize various combinations of formal supports from multiple providers to ensure continuity of services.

During service plan development, the Member's case manager assesses the Member's risks and develops a service plan that addresses the risks as well as the back-up plans for management of risks. In this process, the Case Manager educates the Member regarding potential risks and options to address risk to obtain Member informed choice of options. The Case Manager provides advocacy support to the Member in development of service delivery to honor Member preference for level of risk acceptance and for risk mitigation measures built into the service plan including the particular back-up services selected and the manner in which back-up services are delivered.

Case Manager support and advocacy for individual Member preference occurs during service plan development and, thereafter, as needed.

Service Plans are submitted to the OHCA Care Management Team for review and authorization. The Service Plan Authorization team uses defined processes to further assess and address risk factors. Service Plan Analysts complete a detailed non-clinical review of every new Service Plan and Reassessment Service Plan using the following high risk indicators:
• UCAT Mental Status Questionnaire (MSQ) score over 18.
• Lives alone with MSQ over 12.
• History of falls.
• Evidence of wounds.
• Medication management issues.
• Ventilator dependent.
• APS involvement.
• Unable to transfer or evacuate the home independently.
Unable to ambulate without assistance and is left alone for periods of time.
• Unable to use telephone or PERS device.
• Need for 24 hour support is documented but is not provided per Service Plan.
• Severe mental health conditions / risk of harm to self or others.
Environmental hazards are identified by assessor.
• Request for personal care and / or ASR hours in excess of 30 per week.

Service Plans with any of the above indicators are forwarded to the Service Plan Authorization Supervisor, an RN in OHCAÂ's Care Management Department, for additional review. Plans are then reviewed in detail for addressing of identified indicators, including back-up, per Service Plan Goals. Outcome of the reviews are as follows:
• Service Plan is determined to have addressed all identified risk factors, no further action is taken.
• Service Plan has not addressed risk factors; the case management provider must submit revised documentation which addresses issues in order for the service plan to be approved.
• Identified issues are significant enough to warrant escalation to the OHCA Clinical Review Team. An RN Exceptional Needs Coordinator investigates the issue by contacting the case manager, collaboration then occurs for appropriate addressing and/or resolution of the issue(s).

At a minumum, back-up plans are developed for the following services:
1. Direct service worker
2. Critical health or supportive services
3. Equipment repair or replacement
4. Transportation

For each back-up plan, the provider agency is the first tier of back-up support. As a secondary tier, the member's informal supports may give their consent to provide the critical service in the event it is needed for the member. The third tier back-up support for members is the toll-free number, 888-287-2443, which is answered by the Long Term Care Waiver Operations division. For extreme emergencies that rise to the fourth tier level, the 9-1-1 emergency statewide call system is to be used.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

During assessment for LOC medical eligibility and/or service plan development, the Case Manager informs the member and family of agencies certified to deliver Case Management and in-home care services in the local area to obtain the member's primary and secondary informed choices. The case manager documents the names of the chosen agencies and the agreement (by dated signature) of the member to receive services provided by the agencies.

After completing the in-home assessment, as part of the planning process, the Case Manager should discuss service options for meeting member needs. The list of qualified service providers in the local area is reviewed with the member and the member's legal representative, in consultation with the Case Manager, member then selects a provider to deliver each service. If the member or his/her legal representative declines to make a provider choice, the Case Manager notifies the OHCA Care Management Team to initiate the rotating system to select an agency for the member from a list of local certified case management and in-home care agencies. OHCA gives the Case Manager the name of the agency identified through the rotating system. The Case Manager then documents the selection on the Medically Fragile Freedom of Choice form. The Case Manager also documents the name of the chosen agency and the agreement (by dated signature) of the member to receive services provided by the agency. The Long Term Care Waiver Operations division provides ongoing monitoring through 100 percent chart review monthly to ensure that the auto selected provider was chosen according to procedures.

On an ongoing basis, the Case Manager consults with the member and determines if the member would like to know if any additional service providers are available. The Case Manager will furnish this informaiton at any time the member requests information about available service providers. Members may also look on our web page for information about Medically Fragile waiver providers, querying by provider type and by the counties served.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Authorization of service plans and amendments to service plans. The OHCA Care Management Team authorizes the individual service plan and all service plan amendments for each member using protocol and criteria established by the Medicaid Agency. Once the team verifies eligibility, plan cost effectiveness, that service providers are authorized and have executed a Medicaid agreement, and that the delivery of services is consistent with the member's level of care need, the service plan is authorized.

The OHCA Care Management Team uses the ATLANTES clinician-designed care management system for service plan review and authorization.

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):*

- [x] **Medicaid agency**
- [ ] **Operating agency**
- [x] **Case manager**
- [ ] **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

(a) A certified Case Manager employed by a qualified Case Management provider agency is responsible for monitoring the implementation of the service plan and participant health and welfare. The Case Manager will ensure that services are provided in accordance with the service plan, member access to waiver and non-waiver services as identified in the service plan, members' exercise freedom of choice of providers, how services meet members' needs and effectiveness of members' back-up plan. This continuous monitoring of the implementaton of the service plan ensures that waiver services meet the member's need and achieve their intended outcomes. This monitoring is also conducted to identify any problems related to the member's health and welfare that may require action.

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

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

At a minimum, quarterly in-home Face-to-Face visits with the Member are required.
When a Member is un-staffed, the case manager contacts the Member and Home Care Agency weekly to provide more frequent monitoring of health and safety, major life changes, possible need to change providers; and to monitor the recruiting activities of the provider to determine when and if a change of provider is indicated. Weekly phone call monitoring occurs until Member is staffed.

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

Minimum Components of Agency Policies and Procedures:
1. The case management agency defines high risk and sets criteria for monitoring high risk Members.

2. The case manager develops an individualized High Risk Plan in conjunction with the Member's Service Plan.
3. The case management agency provides heightened supervisory and administrative scrutiny of high risk monitoring activities.

(c) Within five working days of notification of an initial or new service plan authorization, the Case Manager visits the member in his/her home and evaluates the progress of the service plan implementation.
Thereafter, the Case Manager evaluates service plan implementation on the following minimum schedule:
(1) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and
(2) monthly after the initial 30 day follow-up evaluation date.

The State ensures that the case management agencies provide for prompt follow-up and remediation of identified problems. The case manager addresses any problem identified with the service plan implementation. This may include amending the service plan to more appropriately address the member's needs, as assisting the member with a change in providers as necessary.

Long Term Care Waiver Operations (LTCWO) staff receives monthly reports from case management agencies that are used for systematic collection and compilation of information about service plan monitoring. This infomation includes data about all member's status that is compared with OHCA service plan data, as well as member reported information in the Member Inquiry System. Information is analyzed and trended monthly and quarterly to ensure that service plans are monitored accurately and member needs are appropriately and timely addressed.

Long Term Care Waiver Operations staff will initiate immediate follow up and remediation of any identified problems related to service plan implementation.

b. Monitoring Safeguards. *Select one:*

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

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

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

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

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

Service plans are reviewed by the OHCA Care Management Team prior to approval both with regard to the plan services meeting assessed needs and with regard to service units appearing to be appropriate to meet assessed needs.

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

At a systems level, the OHCA Long Term Care Waiver Operations Division (LTCWO) maintains a Member Inquiry System (MIS) to register member, Member family or provider complaints, problems or incidents. MIS is accessed via a toll-free 800 number. As part of orientation, each member is provided information about MIS and the 800 number by the Case Manager. MIS is supported by a database system to track complaints/incidents,

assignment of LTCWO staff to investigate, to track resolution process and record actions and resolution for each complaint or incident.

Quality of service delivery performance of all providers is monitored by OHCA (Provider Audits) and (Provider CQI monitoring and Provider re-certification). Individualized reports for provider complaint/incident are produced for tracking by provider agency case managers. A review of Home Care based Case Management providers is conducted to compare them with other Case management providers. Aggregated MIS data reports are regularly produced that report activity by type of complaint/incident by Home Care associated and non-Home Care associated Case Management providers. These reports are utilized to identify patterns of incident or problem types requiring attention or patterns of complaints/incidents that may alert OHCA of potential quality problems with individual providers.

Service authorization and utilization for members using Home Care providers who provide Case Management and those using other Case Management provider services are compared for comparability of service utilization.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Percent of Service Plans that reflect all the individual's assessed needs including personal goals either by provision of waiver services or other means. Denominator: Number of Service Plans Numerator: Number of Service Plans that reflect all the individual's assessed needs including personal goals

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of Service Plans that reflect all the individual's assessed needs including health and safety risk factors either by provision of waiver services or other means. Denominator: Number of service plans. Numerator: Number of Service Plans that reflect all the individual's assessed needs including health and safety risk factors.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Service Plan

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of service plans developed using processes indicated in Appendix D-1-D of the waiver application. Denominator: Total number of Service Plans developed Numerator: Total number of IDT checklist received

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Percentage of Service Plans updated/revised annually. Denominator: Service Plans reviewed Numerator: Service Plans updated/revised no less than annually

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Plans and LTCWO Report and IDT Checklist

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of Service Plans revised and updated prior to annual review based upon amendments received due to changes in members' needs. Denominator: Service Plans Reviewed Numerator: Service Plans revised and updated prior to annual review due based upon amendments received due to changes in members' needs.

Data Source (Select one):
Other

If 'Other' is selected, specify:

Service Plans, Amendments and LTCWO Report

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Percentage of service plans in which services were provided in the type, scope, amount, duration and frequency specified in the service plan. Denominator: Service Plans reviewed Numerator: Service plans in which services were provided in the type, scope, amount, duration and frequency specified in the service plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Claims data Service Plan

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

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Percentage of members offered choice by documentation between waiver services and institutional care. Denominator: Number of Consents and Rights form Numerator: Number of members offered choice by documentation between waiver services and institutional care

Data Source (Select one):
Other
If 'Other' is selected, specify:
Consents and Rights form

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of members offered choice between/among waiver services and providers. Denominator: Consents and Rights forms received. Numerator: Forms documenting member was offered choice between/among waiver services and providers

Data Source (Select one):
Other

If 'Other' is selected, specify:
Consents and Rights form

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Service plans are reviewed by the OHCA Care Management Team prior to approval both with regard to the planned services meeting the assessed needs and with regard to appropriate service units. When the team identifies a problem with the service plan, the team will in accordance with its policies and procedures review the UCAT score to ensure that the service plan addresses the member needs. The team and/or LTCWO will also review the plan to ensure the services are delivered in accordance with the service plan including the type, scope, amount, duration and frequency specified in the state plan.

Based on information reviewed from claims data, service plans and member surveys and individual audits, the State will provide a report of the findings in order to make adjustments to the member's service plan if necessary.

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

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

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

- ◉ **No**
- ○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

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

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

a) Members of the medically fragile waiver will have greater flexibility to self-direct their services through three approaches to self-direction: self-direction, self-direction with supports and the common law model of self-direction.

With the self-direction service model, members of the medically fragile waiver will be able to recruit, hire and train their personal care attendants. With this option, members of the medically fragile waiver will also develop their own 24 hour back up plans with assistance from their planning team. The member is also the employer of record and has budget authority in terms of the salary of the personal care attendant.

In the self-direction with supports model, the individual is the employer of record, but he or she shares the other responsibilities of recruiting, hiring and training staff with an agency or an advocate. Individuals who choose either of these self-direction options will receive assistance from the fiscal agency contracted with the OHCA to provide these services.

Individuals may also choose the common law employer model of self-direction. The individual supervises, hires and discharges directly. The member or the member's representative is liable for the performance of necessary employment-related tasks and uses the Medically Fragile fiscal agent.

b) The case manager for members of the Medically Fragile waiver will inform the member of the option to self-direct their care upon enrollment in the waiver. During the service planning process, the case manager (with assistance from the service planning team) will assess whether or not the member requires assistance and or training in order to self-direct their services. If training in self-direction and responsibilities is needed, the case manager will inform the member of the resources available to provide this training.

The case manager will also give information to the member about the option to terminate self-direction or change to the agency directed model of service delivery. If the member terminates self-direction, the case manager will ensure

that the same quality of self-directed services is available to the individual through an agency model.

c) The OHCA along with Provider Agencies will coordinate self-directed services for waiver members. The fiscal agent contracted with the OHCA will perform financial management and payroll services to members who choose to self-direct their care.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

Members may self-direct services if they meet the following criteria:

* Have an existing need for self-directed services to prevent institutionalization

* Assurance of member health and safety with self-directed services can reasonably be made based on a review of service history records and a review of consumer readiness (a self-assessment of capacity to assume reponsibilities as employer of their provider)

For self-direction, the member's health and safety is dependent on the member's capacity and willingness to assume an active role in service planning, provider recruitment, training, management and supervision, self-directed service budgeting and fiscal management, monitoring and managing health and preparation for emergency back up. LTCWO reviews service history and member readiness assessment to evaluate member capacity and willingness to assume responsibility. The waiver program provides support to the self-directing member in each area in which the review indicates member requires assistance. The Case Manager assists with service and emergency back up planning. An FMS assists, as needed, to prepare equipment and assist the member in the employer role to recruit, train, manage and supervise the provider, and to assist with self-directed services budgeting and fiscal management. A skilled nurse may assist, as needed, in training the provider on tasks requiring clinical expertise and in monitoring and addressing member-specific health conditions.

A review of service history records and consumer readiness assessment that identifies any of the following forms the basis for denying a request to self-direct due to inability to ensure member health and safety:

* The member is not willing to assume responsibility, or to enlist an "authorized representative" to assume responsibility in one or more areas of self-direction; or,
* The member has a recent history of self-neglect or self-abuse within the past twelve months that is confirmed by Adult Protective Services and does not have an "authorized representative" with capacity to assist with self-direction responsibilities.

If review of service history records and consumer readiness assessment indicate that a member, or member along with an "authorized representative" to assist them, demonstrates minimal capacity to assume self-direction responsibilities but the member chooses to participate, the Case Manager and FMS provide supports to the member to fully implement self-direction. Only upon documentation by the Case Manager and FMS of failure, in spite of support efforts, to develop and implement a self-directed plan that would protect consumer health and safety, will the self-direction option for a member be discontinued. Agency Personal Care services to a member continue until self-direction is fully implemented.

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

The following process is used to provide member direction options to the waiver participants. Upon enrollment in the waiver, members will be informed by their Case Managers of the opportunities for self-direction. Participants will receive information that specifies the following:

• The self-direction options offered
• The services that may be self-directed
• A list of the responsibilities of the individual with each self-directed option
• Resources and training available to individuals who choose self-direction

The Case Manager will be responsible for providing information about self-direction to each member upon their enrollment in the waiver. The member may request self-directed services from the Case Manager or call the Member Inquiry System toll-free number, 888-287-2443, to request self-directed services.

The member must make a voluntary Informed Choice to participate in self-direction. To support the decision-making process, the Case Manager will provide the member and, as applicable, their designated "authorized representative" or "legal representative" an overview orientation to self-direction, including the member's role as Employer and the role

of each of the other participants in this unique service delivery system.

As part of the informed choice decision-making process for self-direction, the Case Manager will provide consultation and assistance as the member completes a self-assessment of prepardness to assume the role of Employer of their Personal Services Assistant. The orientation and enrollment process will provide the Member with a basic understanding of what will be expected of them under self-direction, the supports available to assist them to successfully perform Employer responsibilities and an overview of the potential risks involved. The self-assessment is meant to provide the member with a realistic picture of what participation in self-direction will mean - to better understand the investment of time, effort and committment that may be required on their part. The "Self Assessment of Readiness" to assume self-direction Employer role and responsibilities is on file with the State Medicaid Agency. The Member indicates their decision to "Select" or "Not Select" the self-direction service option on the "Self Assessment of Readiness" form.

For each member that "Selects" self-direction, the Case Manager provides a Medically Fragile program refresher orientation in which basic explanation and information regarding freedom of choice of providers, appeal rights and processes, complaint registration/resolution process along with the toll free number access, risk management initiation and process, roles and responsibilities of member, CM, FMS and other service providers, member reassessment and service plan review schedule for the particular member and requirement for emergency back-up plan or presented.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

The member designates an "authorized representative" to assist with his or her employer responsibilities. The designated authorized representative advise and assist the individual regarding any and all self-direction activities and decision for which the member is responsible and take actions on behalf of the member when directed by the member. If the member chooses to designate and authorized representative, the designation identifying the "willing adult" to assume this role and responsibilities is documented with dated signatures of the member, the designee and the member's Case Manager.

A person will not make decisions for or on behalf of a member unless he or she has the legal authority to make decisions on behalf of the member. In order to be an authorized legal representative, the person must be the legal guardian for the member or have a durable power of attorney for the member. An individual who is hired by the member to provide a service will not serve as an authorized representative or a legal guardian for the member.

The case managers monitors service delivery and the performance of the member's authorized representative or legal representative to determine if he or she is functioning in the best interest of the member.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Personal Care	☑	☑
Advanced Supportive/Restorative Assistance	☑	☑
Respite	☑	☑
Self-Directed Goods and Services (SD-GS)	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

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

The FMS provides the administrative financial management of the program for members who self-direct their services in this waiver. The fiscal agent in Oklahoma is selected as a result of a competitive bid following procedures outlined in the Oklahoma Central Purchasing Act.

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

The FMS is compensated for administrative services as part of bundled administrative funds for administrative responsibilities of the waiver. The fiscal agent is paid a flat monthly rate for each member. A flat monthly

rate is charged each member's budget per month that the member self-directs.

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

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

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

Specify:

Administrative financial management services include assistance with cognitive tasks, decision-making and specialized skills including assistance with individual budgeting. Additionally, financial management services provides an orientation and training regarding employer responsibilities to support and assist the member to successfully perform the employer related functions.

Supports furnished when the participant exercises budget authority:

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

Specify:

The financial management services provided by the FMS assists waiver members with developing the budget allocation. The FMS verifies that all self-directed service providers hired by the member meet service provider qualifications and coordinates a Medicaid provider agreement with each provider prior to hire.

Additional functions/activities:

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

Specify:

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

a) OHCA Long Term Care Waiver Operations staff review monthly expenditure reports and claims paid by the fiscal agent. OHCA monitors the fiscal agent by reviewing monthly statements, comparing payroll data and reviewing invoices submitted on behalf of each member.
b) LTCWO staff has oversight and responsibility for the claims paid by the fiscal agent.
c) LTCWO staff generates monthly reports to monitor the fiscal agent. These reports summarize information

about the contractual compliance of the FMS with terms of the contract scope. This includes payroll reports, information and assistance furished to self-directing members, budget allocation reports and performance of customer service duties in assisting members.

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:

Self-Directed Services Information and Assistance

The member freely chooses a Case Management provider. The Case Management provider agency assigns the member a Case Manager that has successfully completed training on Self-Directed Services, including training on Independent Living Philosophy and Person-Centered planning. Case Managers that have completed this training may provide service planning and support to self-directing members, as noted in C-3.

Person-Centered planning is a process directed by the member, with assistance as needed from an authorized representative or support team. The process supports the member in exercising choice and control. The member assumes a responsible role in developing, implementing and managing his/her services and supports. The process is intended to identify the strengths, capacities, preferences, needs and desired outcomes of the member. It may also enlist assistance from individuals freely chosen by the member to serve as important contributors. The person-centered planning process enables the member to identify and access a personalized mix of paid and non-paid services and supports to help him/her achieve personally-defined outcomes in the most inclusive community setting. The focus of person-centered planning is on the member's development of personal relationships, positive roles in community activities, and self-empowerment skills. Decisions are made and outcomes controlled by the member. Strengths, preferences and an individualized system of support are identified to assist the member to achieve functional and meaningful goals and objectives.

Principles of Person-Centered Planning are as follows:
1. The person is the center of all planning activities
2. The Member and their representative, or support team, are given the information to assume a controlling role in the development, implementation and management of the Member's services
3. The individual and those that know and care about him/her are the fundamental sources of information and decision-making.
4. Person-centered planning results in personally-defined outcomes.
5. The individual directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals and support needs.

The Member, or as applicable their designated "authorized representative", is given the option to direct the Medically Fragile service planning process. The Member determines who, in addition to the Case Manager, to include in the planning process. The process is to enable and assist the Member to identify and access formal (paid) and informal (non-paid) supports and services to achieve personally-defined outcomes. For Medically Fragile Members, the Person-centered planning process is to be used for development and revisions of the Member's service plan, including all services, not just for informal support services. Through the planning process, the Member's strengths, capacities, preferences, and needs are identified and planning goals and desired outcomes are defined. The Service Plan specifies services, both formal and informal, service providers, units of service authorized and begin and end dates for services authorized.

The Case Manager will provide support to the Member in this Person-centered planning process, including

providing information about qualified providers of services and information on community resources for informal and non-waiver formal services of interest to the Member. The Case Manager is responsible for submitting the developed plan to the OHCA Care Management Team for approval.

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

Whenever a Member and a Provider of services cannot agree about a service, or about appropriate frequency, duration or other aspect of the service, or disagree about a behavior/action of the member, or of the provider, and either the Case Manager, the provider or the Member, or the member's family or authorized representative, believe that the disagreement poses a significant risk to consumer health or safety, the Case Manager uses the Risk Management process to resolve the disagreement. If the behavior/action of the Case Manager is in dispute the LTCWO Risk Management process will be used to resolve the disagreement. The LTCWO Risk Management process includes guidelines and criteria for determining circumstances under which to invoke the process, parties to include in the process and the timeline for process resolution. An evidence based evaluation process to determine risk to member health and safety, requirements for a consensus agreement on "reasonable acceptable risk," and process documentation forms, including a requirement for a summary statement of resolution agreements and actions to be taken, are included.

☐ **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
Personal Care	☐
Hospice Care	☐
Private Duty Nursing	☐
Specialized Medical Equipment and Supplies	☐
Personal Emergency Response System (PERS)	☐
Therapy Services: Occupational	☐
Case Management	☐
Advanced Supportive/Restorative Assistance	☐
Respite	☐
Institutional Transition Services	☐
Therapy Services: Physical	☐
Home Delivered Meals	☐
Environmental Modifications	☐
Self-Directed Goods and Services (SD-GS)	☐
Prescribed Drugs	☐
Therapy Services: Respiratory	☐
Therapy Services: Speech	☐
Skilled Nursing	☐

☐ **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:

Waiver members may voluntarily terminate any services at any time including self-directed personal care services and self-directed supports and services. For waiver members, the case manager will assist individuals with termination of self-directed personal care and replacement with selected provider. Existing services continue as authorized, or the Member's backup plan of choice is implemented, until agency replacement services begin. The member's case manager will respond to the member's request for termination of self-directed services within two working days.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination of member directed services may occur if it is determined through documentation that the individual can no longer effectively self-direct their services due to:
• Participant abuse or exploitation of their employee;
• Participant falsification of a time-sheet or other work record;
• Participant, even with FMS assistance, is unable to operate within their individualized budget amount; or,
• Inferior quality of services provided by member's employee jeopardizes member's health and/or safety.
• Individual does not have an authorized representative who can assume these responsibilities on the individual's behalf.

The case manager will assist individuals with termination and replacement with the provider agency model of service to ensure continuity of service and member health and welfare during the transition period if involuntary termination of member self-direction occurs.

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

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**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [ ] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The individual/representative, along with his or her Case Manager develops the service plan that includes a budget for the services that are self-directed. The individual's service plan determines the intensity, frequency and duration of needed services.

The amount budgeted for services includes reasonable costs based on the approved rate structure and funding available for each service. The Case Manager completes the service plan and the budget, the OHCA Care Management Team reviews the budget and service plan to assure compliance with cost methodology within the waiver program. When the service plan is approved, the fiscal agent assigns a budget for each self-directed service.

The interdisciplinary team meets monthly and reviews how the budget is spent and amends previous spending decisions as needed. Changes to the budget must be reviewed by the OHCA Care Management Team and submitted to the fiscal agent for action.

The calculation tool and description of the Individualized Budget Allocation (IBA) Expenditures Accounts Determination process are on file with OHCA. In addition, the description of the IBA process is maintained by the Office of Administrative Rules within the Office of Secretary of State and posted on the Secretary of State website.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The individual and his or her team decide how the budget for the service plan is allocated. The team establishes the budget for the individual service plan and the individual is the leader of his or her team. The Case Manager educates the individual on the established rates for each service and the range that can be paid for each service eligible for self-direction. The Case Manager informs the member of the established budget amounts and obtains the member's signature on the proposed budget and service plan. The team submits the budget to the OHCA Care Management Team for approval prior to finalizing the service plan. The fiscal agent advises the member of the confirmed budget allocation after the service plan has been approved. A copy of the approved budget is given to the member. Each month the FMS provides the member detailed information of expenditures for the previous month and overall budget status.

During monthly team meetings, the individual and his or her team reviews the monthly budget. Any requested changes to the budget must include a change to the individual service plan. If an individual desires to change the rate of pay for a personal care attendant and this increases the service plan cost, the service plan must be reviewed by the team and submitted to the OHCA Care Management Team for approval. If the individual

changes the rate of pay for a personal care attendant and it does not increase the total amount of the service plan budget, the team does not have to submit this modification to the OHCA for approval. If the team requests a budget modification and the modification is denied by the OHCA, the individual may request a fair hearing through the OHCA's Legal Division. The OHCA hearing officer reviews the issue and makes a determination for the individual.

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 individual budget is developed with the input from the individual, the Case Manager and members of the interdisciplinary team. The team meets monthly (or more often if needed) to review the status of the individual's budget allocation. The monthly status report includes the expected expenditures and the actual expenditures and monthly balance for each service. The OHCA Care Management Team reviews these reports and document any budget variance. Staff of the fiscal agent reviews budget variances with the Case Manager and members of the interdisciplinary team. The Case Manager reviews the variance with the member and assist the member in making any needed adjustments to stay within the budget allocation.

Additionally, the case manager evaluates monthly the adequacy of service delivery and member satification with services. If the case manager determines that the allocation is inadequate, the case manager should request an amendment to the member's budget.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Fair Hearings regarding eligibility are heard by OHCA. Applicants for the waiver are informed of this opportunity in written information presented in the first meetings with the member about the Medically Fragile Waiver.

Service appeals are heard by OHCA. If a participant or applicant believes he or she was not given a choice of home and community-based services as an alternative to institutional care, denied the services of their choice or the provider of their choice, or whose services are denied, suspended, reduced or terminated, the individual may request a hearing through the OHCA Legal Division. At the hearing, the individual will have the opportunity to express his or her concerns to the hearing officer. The individual may be represented by counsel if they desire. This is described in OAC 317:2-1-2.

In addition, all residential provider agencies are required to have a policy and procedure detailing their complaint and resolution process and provide this information to the individual. Individuals participating in the Medically Fragile waiver will also have access to the MIS toll-free number, 1-888-287-2443.

During the assessment visit to establish medical eligibility, the Case Manager explains to the Member (and/or his/her legal representative) his/her rights to a Fair Hearing (Part D of the Member Consents and Rights form) as well as how the Member may request a Fair Hearing.

In addition, as part of the application process, the applicant is notified by the OHCA worker of his/her rights and responsibilities including the right to a fair hearing. These are listed on the Member Consents and Rights form. The applicant has the right to:

• be treated equally regardless of race, color, age, sex, handicap, religion, political belief, or national origin
• have information kept confidential, unless directly related to the administration of OHCA programs
• request a fair hearing, either orally or in writing if the applicant disagrees with any action taken
• be represented at the hearing by a designee
• have the application processed promptly
• obtain assistance from OHCA in completing this application or in obtaining required verification
• reapply at any time benefits stop
• receive information about programs administered by OHCA.

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

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

The member also receives written information about the right to request a Fair Hearing and the steps in the process regarding appeals with respect to services. The member is to use the LD-1 form to file a request. The LD-1 form is to be mailed to:
Oklahoma Health Care Authority
Grievance Docket Clerk
Legal Division
P.O. Drawer 18497
Oklahoma City, Oklahoma 73154-0497

OHCA Fax Number is (405) 530-3444
OHCA Docket Clerk Telephone Number is (405) 522-7217

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

OHCA understands that the members eligible for this waiver have many needs that affect their medical services while being served in the community. Moreover, the agency recognizes that an additional dispute resolution process would be helpful for persons who desire additional medical service beyond those authorized by the agency.

Therefore, the agency will offer dispute resolution in addition to the fair hearing process; however, the member is informed that making use of the dispute resolution process is not a pre-requisite or substitute for the fair hearing process. Additional dispute resolution is available for both eligibility and medical services dispute issues. Dispute resolution must be concluded within 45 days of the request by the member. The process begins with an application for additional dispute resolution. Additional dispute resolution will be conducted between the member, legal services and OHCA care management unit. It may involve a meeting with the member in their home. No admission against interest made in the additional dispute resolution process may be utilized as evidence by parties at the fair hearing.

The additional dispute resolution process will attempt to include other state agencies as well as other social services to the extent they can help the member with their medical needs. Additionally, the additional dispute resolution process will be used to resolve disputes regarding medical care.

If dispute resolution does not resolve the member's dispute, the fair hearing process will continue.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

The Oklahoma Health Care Authority operates the Grievance/Complaints system referred to as Member Inquiry System (MIS) at 1-888-287-2443.

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).

OAC 317:2-1-2 describes OHCA's appeals process. A grievance allows a member to appeal a decision which adversely affects their rights. A decision regarding services, for example, can be appealed by the member.

In contrast, a complaint is a concern reported by a member that requires the assistance of program staff.

Members may express a complaint or file an appeal as needed.
(a) The member is informed by the OHCA staff and by the Case Manager of the member's right to receive a fair hearing regarding any decision with potentially adverse impact on the member. Appeals regarding financial eligibility and services are heard by OHCA. However, when a member elects to file a grievance or make a complaint, the member is informed that doing so is not a pre-requisite or substitute for a Fair Hearing. Members are informed by

their case manager of rights to fair hearing during the time of enrollment. Member signature on the MedFrag Consents and Rights form acknowledges their receipt of these rights.

(b) All waiver members are informed in writing that they should direct all complaints to the MIS toll free phone number at 1-888-287-2443. Summary of each complaint will be documented in ATLANTES. The analyst who receives the call will determine the course of action based on procedures indicated in the procedures manual. Complaints related to the member's health and safety will be immediately addressed. The procedures manual also lists the timelines for initiating a response to member complaints. Resolution of all complaints will be documented in ATLANTES.

The member also receives written information outlining the appeals process for filing grievances, as described in appendix F-1 above. The LD-1 must be filed within 20 days of the triggering event. Member appeals are normally heard within 90 days. However, an expedited process can be utilized, with a final decision rendered in approximately 48 hours.

(c) Direct communications with the provider agencies serving the members are used to resolve member complaints. The complaint tracking system allows for trend reporting of member complaints against provider agencies. These provider reports are also considered during provider audits and in provider agreement monitoring. The State will take action based upon review of complaint data.

In addition, the State has Fair Hearing and formal appeal processes available to every member in the waiver. The formal grievance process may include a hearing before an Administrative Law Judge. The member is also informed that if assistance in reading or completing the LD-1 form is needed that arrangements will be made.

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).

It is the policy of OHCA that any serious incident that harmes or potentially harms a member's health, safety or well being is immediately identified, reported, reviewed, investigated and corrected. This policy will not supersede any federal, state or regulatory body statutes, laws or regulations. The Critical Incident Reporting and Tracking System addresses all member incidents listed and defined by the policy. As required by state law, responsible parties must report abuse, neglect and/or exploitation. Adult Protective Services is the designated State Agency lead with investigative authority in the event of critical incidents involving abuse, neglect or exploitation. It is the expectation that the Provider Agency that first identifies a critical incident report the incident to OHCA/LTCWO on the appropriate form within one business day. The member's case manager, with the support of OHCA, facilitates the evaluation and/or investigation process of the critical incident.

The state has adopted the definitions of abuse, neglect and exploitation outlined in the State of Oklahoma statute (O.S. 43 § 10-103. Definitions):

Abuse: "Intentional infliction of physical pain, injury, sexual abuse or mental anguish or the deprivation of food, clothing, shelter, or medical care to a vulnerable adult by a caretaker or other person responsible for providing these services" (O.S. 43 § 10-103. A.8).

Neglect: "Failure to provide protection to a vulnerable adult who is unable to protect the person's own interest; or the failure to provide adequate shelter or clothing; or the harming or threatening with harm through action or inaction by either another individual or through the persons own action or inaction because of a lack of awareness, incompetence, or incapacity, which has resulted or may result in physical or mental injury" (O.S. 43 § 10-103. A.10).

Exploitation: "An unjust or improper use of the resources of a vulnerable adult for the profit or advantage, pecuniary or otherwise, of a person other than the vulnerable adult through the use of undue influence, coercion, harassment, duress, deception, false representative or false pretense" (O.S. 43 § 10-103. A.9).

Other definitions listed in the statutes include: self-neglect, verbal abuse, sexual exploitation.

In accordance with the State of Oklahoma statute (O.S. 43 § 10-104.A), "any person who has reasonable cause to believe a vulnerable adult is suffering from Abuse, neglect or exploitation shall report the situation to authorities as soon as the person is aware of the situation. Reports can be made to the Department of Human Services Adult Protective Services program, the local district attorneys office, or the local police or sheriff's department. Reporting is the individual responsibility of the person who believes the situation to be one which should be reported."

In addition, the State of Oklahoma statute (O.S. 43 § 10-104.B) states that, "although the reporting requirement applies to everyone, certain professionals are specifically required by law to report situations." These include, but are not limited to, social workers, mental health professionals, and other medical professionals.

The Provider is responsible for completing their own internal investigation of all Level I critical incidents, unless they have been directed not to do so from an authorized government entity. Level II and Level III incidents require further investigation if the provider determines this as necessary after an initial evaluation is completed. All investigative reports are submitted to the OHCA or designee within 10 working days after the initial Critical Incident Report is completed. When a provider becomes aware of a critical incident, the provider must inform OHCA's LTCWO Division within one working day.

The Provider Agency reviews all critical incident reports and determines the appropriate response to each incidence (evaluation or investigation). The Provider Agency coordinates their investigative efforts with governmental investigative authorities as required by State or Federal law. The Provider Agency uses the following criteria in determining whether an evaluation response is adequate for resolution of the critical incident:
An adequate description of the incident has been obtained
The critical incident is either a Level II or Level III
Documentation reflects the assessment of the illness or injury and its impact to the Participants health and welfare
Documentation reflects that appropriate action has been taken to assure the Participants continued health and welfare
There is no history of similar events in previous incidents in Participants community home in the past six months (unless there is a documented plan indicating an agreed upon procedure that has been followed, i.e. a Participant has a seizure disorder and a plan has already been developed of how to manage a resultant fall).

The OHCA or designee reviews all critical incident reports and determines the appropriate response to each incidence occurred, (evaluation or investigation). The OHCA or designee coordinates their investigative efforts with governmental investigative authorities as required by State or Federal law. The OHCA or designee uses the following criteria in determining whether an evaluation response is adequate for resolution of the critical incident:

An adequate description of the incident has been obtained
The critical incident is either a Level II or Level III
Documentation reflects the assessment of the illness or injury and its impact to the Participant's health and welfare
Documentation reflects that appropriate action has been taken to assure the Participant's continued health and welfare
There is no history of similar events in previous incidents in Participants community home in the past six months (unless there is a documented plan indicating an agreed upon procedure that has been followed, i.e. a Participant has a seizure disorder and a plan has already been developed of how to manage a resultant fall).

In the Medically Fragile waiver Conditions of Provider Participation (COPP), Case Management, Home Care, and Hospice providers are required, as part of their Medicaid Agreement, to ensure that necessary safeguards have been taken to assure the health and safety of the Member. This includes removing an employee suspected of abuse, neglect or exploitation until an investigation occurs. Requirements specify that the provider will follow APS process for reporting potential instances of suspected abuse, neglect and exploitation.

Furthermore, the waiver operates a toll free number, 888-287-2443, for inquiries or complaints from Members, providers, or others. OHCA staff reports any suspected incidence of abuse, neglect or exploitation to APS.

The Oklahoma Department of Human Services website for Adult Protective Services (http:www.okdhs.org/APS/printer.html § 5.C) offers the following guidance on reporting potential abuse, neglect and exploitation, "The best way to make a report to the Department of Human Services is to contact the APS supervisor who has responsibility for the county where the vulnerable adult lives." Supervisor contacts for each county are available from a "Contact Us" link for reporting potential abuse, neglect and/or exploitation.

According to State of Oklahoma statute (O.S. 43 § 10-104 C.1.), "if the report is not made in writing in the first instance, as soon as possible after it is initially made by telephone or otherwise, the report shall be reduced to writing by the Department of Human Services, in accordance with rules promulgated by the Commission for Human Services, or the local municipal police, or sheriff's department whichever entity received the initial report.

According to State of Oklahoma statute (O.S. 43 § 10-104 A.2.a.), the person suspecting potential abuse, neglect or exploitation must make the report to the appropriate authorities "as soon as the person is aware of the situation."

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

As part of the Medically Fragile program Conditions of Provider Participation, each Case Management, Home Care, Hospice, and Adult Day Health provider must comply with Member Assurances in the delivery of services. At each new Member's orientation to the waiver the Member's chosen case manager provides in-home orientation and education along with written materials to the Member and his/her selected support systems regarding Member rights and responsibilities, the grievance process and procedures, the case management service emergency phone numbers, the waiver Member Inquiry Services toll-free telephone number, 888-287-2443, health and safety procedures, and how to recognize abuse, neglect and exploitation and the process for reporting any incidents of such. Training and education is documented by the member signing the Member Training and Education Acknowledgement Form; this form is kept in the member's file. The Medically Fragile waiver case managers are responsible for ongoing monitoring of the health and welfare of Members and providing the necessary education and intervention related to abuse, neglect and exploitation of Members. This new member orientation is conducted by the Case Manager within 10 business days of receipt of service plan approval.

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 Long Term Care Waiver Operations (LTCWO) Division reviews reports of critical events or incidents including suspected abuse, neglect or exploitation. When LTCWO identifies instances of potential abuse, neglect and exploitation, these instances are immediately reported to Adult Protective Services. Adult Protective Services (APS) is a program within the Oklahoma Department of Human Services (OKDHS) authorized in Title 43A of the State of Oklahoma statutes, sections 10-101 through 10-111. APS is authorized to investigate any report of potential abuse, neglect or exploitation. All matters referred to APS for investigation are documented in ATLANTES.

While APS does not provide information related to abuse, neglect and exploitation to the waiver program, the OHCA has developed its own internal system for prevention and identification of instances of potential abuse, neglect and exploitation or concerns for the health and safety of the Members.

LTCWO initiates investigations by making a visit to the alleged victim within three working days of receipt of the referral, or, in case of emergency situations, within four hours of receipt. Investigations are to be completed, including all documentation with a report of findings to the District Attorney within 30 days.

For APS investigations, O.S. 43A Section 10-105 C.5.1., states "As soon as possible after initiating an investigation of a referral regarding a vulnerable adult, the Department shall provide to the caretaker of the alleged victim, the legal guardian and the next of kin of the vulnerable adult notification including a brief oral summary and easily understood written description of the investigation process, whether or not the caretaker, guardian or next of kin is alleged to be the perpetrator of the abuse, neglect or exploitation of the vulnerable adult."

Results of investigations completed by LTCWO are communicated to the member, the legal guardian and the next of

kin in no more than five working days.

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 OHCA has developed internal policies, procedures and business rules to address potential instances of abuse, neglect and exploitation and concerns for health and safety. The LTCWO division has mechanisms in place to provide oversight and safeguard the waiver members with respect to the investigation of critical incidents and events.

The Long Term Care Waiver Operations (LTCWO) division provides oversight of the reporting of and response to any critical incidents. LTCWO staff receive provider agency reports of critical incidents and conduct investigations in accordance with policy. This monitoring is ongoing, and critical incident reports are compiled monthly.

LTCWO maintains computer-based systems for storage, retrieval and dissemination of information that supports the Medically Fragile waiver program. These systems allow for performance monitoring of members and providers as well as tracking and reporting of complaints related to health and safety, including abuse, neglect and exploitation. Data compiled in this incident management system is used to prevent re-occurrence and may lead to the implementation of overall system changes.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

(●) **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Adult Protective Services is the designated state agency responsible for investigating any report of unauthorized use of restraints as a form of abuse in accordance with statutory timeframes for such investigations. As noted in Appendix G-1, the Adult Protective Services program is authorized in Title 43A of the Oklahoma Statutes, Sections 10-101 through 10-111. A report can be made to Adult Protective Services 24 hours a day, 365 days a year.

OHCA's Medically Fragile Waiver program administrative oversight methods are delegated to the Long Term Care Waiver Operations (LTCWO) Division. Long Term Care Waiver Operations initiates contact and dialouge with APS to develop a coordinated system for communication between APS and LTCWO regarding abuse, neglect, and exploitation of any Medically Fragile waiver member as part of a comprehensive system-wide critical indicent management system.

LTCWO has processes in place to detect the unauthorized use of restraints during the delivery of waiver services. These processes include Long Term Care Waiver Operations regular monitoring of the member's health and welfare, the performance of periodic provider quality reviews and the Medically Fragile Waiver incidents management system in which unauthorized restraints is a reportable incident.

( ) **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

(●) **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

Adult Protective Services is the designated state agency responsible for investigating any report of unauthorized use of restrictive interventions as a form of abuse in accordance with statutory timeframes for such investigations. As noted in Appendix G-1, the Adult Protective Services program is authorized in Title 43A of the Oklahoma Statutes, Sections 10-101 through 10-111. A report can be made to Adult Protective Services 24 hours a day, 365 days a year.

OHCA's Medically Fragile Waiver program administrative oversight methods are delegated to the Long Term Care Waiver Operations (LTWCO). LTCWO initiates contact and dialouge with APS to develop a coordinated system for communication between APS and LTCWO regarding abuse, neglect, and exploitation of any medically fragile waiver member as part of a comprehensive system-wide critical indicent management system.

LTCWO has processes in place to detect the unauthorized use of restraints or seclusion during the delivery of waiver services. These processes include LTCWO's regular monitoring of the member's health and welfare, the performance of periodic provider quality reviews and the Medically Fragile Waiver incidents management system in which unauthorized restraints or seclusion is a reportable incident.

( ) **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on*

restraints.)

- (●) **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Adult Protective Services is the designated state agency responsible for investigating any report of unauthorized use of seclusions as a form of abuse in accordance with statutory timeframes for such investigations. As noted in Appendix G-1, the Adult Protective Services program is authorized in Title 43A of the Oklahoma Statutes, Sections 10-101 through 10-111. A report can be made to Adult Protective Services 24 hours a day, 365 days a year.

OHCA's My Life; My Choice Waiver program administrative oversight methods are delegated to the Long Term Care Waiver Operations (LTCWO) Division. Long Term Care Waiver Operations initiates contact and dialouge with APS to develop a coordinated system for communication between APS and LTCWO regarding abuse, neglect, and exploitation of any Medically Fragile waiver member as part of a comprehensive system-wide critical indicent management system.

LTCWO has processes in place to detect the unauthorized use of seclusions during the delivery of waiver services. These processes include Long Term Care Waiver Operations regular monitoring of the member's health and welfare, the performance of periodic provider quality reviews and the Medically Fragile Waiver incidents management system in which unauthorized seclusions is a reportable incident.

- ( ) **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

  i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- (●) **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ( ) **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

  i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
Number & percentage of case managment agencies member records reviewed where the member (or family/legal guardian) received information & education about how to recognize & report abuse, neglect & exploitation. Denom: CM member records reviewed Numer: CM member records documenting member/family/legal guardian received infor. & education about how to recognize & report abuse, neglect & exploitation

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of Home Health provider agencies who met Conditions of Provider Participation requirements related to training for the prevention of Abuse, Neglect and Exploitation. Denominator: Home Health provider agencies reviewed. Numerator: Provider agencies that met COPP requirements related to training for the prevention of Abuse, Neglect and Exploitation

Data Source (Select one):
Other

If 'Other' is selected, specify:
Provider Agency Employee File

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percentage of reported incidents of restraints, seclusion or restrictive interventions reviewed following the procedures in the approved waiver. Denominator: Reported incidents regarding use of restraints, seclusion or restrictive intervention Numerator: Reported incidents of restraints, seclusion or restrictive interventions reviewed following approved procedures

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and Percentage of Critical Incidents that are appropriately reported in accordance with OHCA policy. Denominator: Number of Critical Incidents received Numerator: Number appropriately reported in accordance with policy

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

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

Data Aggregation and Analysis:

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

☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of critical incidents requiring review/investigation where OHCA/LTCWO adhered to the follow-up methods as specified in the approved waiver. Denominator: Number of critical incidents received Numerator: Number of incidents reviewed/investigated in adherence with methods specified in approved waiver

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

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number of fair hearing requests received regarding service plan appeals. Denominator: Total number of fair hearing requests received. Numerator: Number of fair hearing requests received regarding service plan appeals.

Data Source (Select one):
Other
If 'Other' is selected, specify:
LD-1 form

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number of fair hearing requests upheld regarding service plan appeals for members participating in the waiver. Denominator: Number of fair hearings regarding service plan appeals. Numerator: Number of fair hearings request upheld regarding service plan appeals for members participating in the waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Notice of action letter

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number of fair hearing requests reversed regarding service plan appeals for members participating in the waiver. Denominator: Number of fair hearing requests regarding service plan appeals. Numerator: Number of fair service plan hearing requests reversed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Notice of action letter

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of member satisfaction surveys that reported unmet needs. Denominator: Total number of surveys received. Numerator: Number of surveys that reported unmet needs.

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

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

Data Aggregation and Analysis:

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

☐ **Continuously and Ongoing**

☐ **Other**
Specify:

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

Performance Measures

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

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

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

Performance Measures

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

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

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

Performance Measures

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Long Term Care Waiver Operations (LTCWO) division reviews reports of critical events or incidents including suspected abuse, neglect or exploitation. When Long Term Care Waiver Operations and Office of Client Advocacy identifies instances of potential abuse, neglect and exploitation, these instances are immediately reported to Adult Protective Services. APS is statutorily responsible for investigating allegations of abuse, neglect, or exploitation of Oklahomans. In accordance with federal law, the State maintains a Nurse Aide Registry that lists certified nurse aides. The Nurse Aide Registry indicates if an aide has been confirmed to have abused, neglected, or exploited a resident of a licensed nursing facility. The Community Service Worker Registry must also be verified prior to employment. Waiver providers must consult these registries prior to offering employment to a non-licensed service provider and refrain from employing that person if either registry indicated the person was confirmed to have abused, neglected, or exploited an individual.

In addition, the State will use findings to update the Waiver QIS as necessary.

When LTCWO detects provider non-compliance with the program requirements, the agency requires the provider to implement a corrective action plan and can apply both financial and administrative sanctions. Following monitoring review, all providers receive a written report that details the specific areas of non-compliance found during the review and includes instruction regarding the provider's responsibility with regard to the areas of deficiency. Long Term Care Waiver Operations then conducts follow-up activities in accordance with the waiver and review procedures to ensure corrective action has been implemented. When appropriate, referrals will be made to Adult Protective Services.

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

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design

changes) prompted as a result of an analysis of discovery and remediation information.

OHCA strives to operate the waiver systematically incorporating the principles of continuous quality improvement. The Long Term Care Quality Initiatives Council (LTCQIC)collaborates for the trending, prioritizing and implementation of system improvement in OHCA waivers. The Council consists of various divisions within OHCA as well as provider agencies, advocacy groups and other stakeholders. The Council meets quarterly to discuss member and provider issues and to set priorities for system-wide quality improvement. The Council receives information from a variety of reports prepared by the LTCWO, Provider Agencies and the FMS. As a result of an analysis of the discovery and remediation information presented to the council, system improvements are identified and design changes are made.

The 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; Long Term Care Waiver Operations staff; Care Management staff, Quality Assurance staff, Legal, Systems, OKDHS, and representatives of Member advocacy groups, and provider agency representatives. The LTCQIC meetings are a public meeting attended by participants and families. In attempts to be more transparent amongst the member and families the State will post minute/reports from LTCQIC meetings on the public website.

ii. System Improvement Activities

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

b. System Design Changes

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

Process for Monitoring and Analyzing the Effectiveness of System Design Changes

As the LTCQIC identifies necessary system design changes, it also establishes the process for monitoring and analyzing effectiveness. The Council sets an evaluation period and ensures that the necessary reports of design changes are brought to the Council.

Roles and Responsibilities for Monitoring and Assessing System Design Changes

OHCA, the State's single Medicaid Agency, has responsibility for and maintains associated quality monitoring and improvement activities associated with the following:
Maintain Oklahoma Administrative Code establishing program policy;
Execute waiver Provider agreements;
Provide MMIS to support operations including member eligibility, provider file, prior authorizations, services and service rates, claims payments, member and provider notification and reports generation;Ensure Program Integrity and Accountability;
Establish service rates and provider standards;

Generate required and/or requested documents and reports for CMS;
Pay Medicaid claims for waiver Program Providers through the CMS-approved MMIS;
Maintain Medicaid Management Information System (MMIS); and
Conduct monthly monitoring of member eligibility and waiver program Plan of Care approval processes.

OHCA is the eligibility agent for the waiver program. OHCA has responsibility for and maintains associated quality monitoring and improvement activities associated with the following:
Ensure that Medicaid eligibility and waiver program enrollment are conducted in accordance with OHCA policy;
Track and validate eligibility data in MMIS;
Conduct Eligibility/Service Appeal Hearings;

LTCWO/OHCA is responsible for and maintains associated quality monitoring and improvement activities associated with the following:
Certify/monitor Providers as qualified" to provide identified waiver services by meeting all standards and conditions of provider participation and to participate in the Medicaid Program;
Train Case Managers and provide program orientation.
Establish and maintain repository of member records;
Authorize member service plans and enter prior authorizations in MMIS;
Provide Long Term Care Information/Application/Referral services;
Operate member complaint/resolution service system;
Conduct research to identify member needs and service gaps, to design new or modify existing systems or services to meet needs and/or improve waiver program services or service delivery.

To effectively monitor, evaluate and impact quality across a complex and multi-layered system of service delivery requires multiple ongoing activities by staff associated with independent system members. The LTCQIC follows a path of engaging people at all levels striving for the continual enhancement and improvement in the value of the waiver program for all stakeholders.

LTCWO has designated staff that is responsible for Continuous Quality Improvement (CQI) activities related to waiver program functions and responsibilities. At least annually, CQI leadership along with administrative leadership within the agency review priorities and strategies for remediation/improvement and summarize these priorities in the Quality Oversight Plan.

Targeted Standards for Systems Improvement
As the LTCQIC over time implements systems improvements, targeted standards will be developed and monitored.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The LTCWO division annually evaluates the Quality Improvement Strategy of the waiver to assure that the state's capacity to discover and document quality issues and program performance is maintained.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) The 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 perfoms annual audits seperately and apart from the operating Medicaid agency (OHCA).

(b) LTCWO 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. In addition, OHCA Program Integrity and Accountability conducts audits on waiver services.

(c) Errors in provider claims include (1) claims payment without corresponding documentation of service delivery and (2) claims payment in excess of service plan authorization. Claims error incidence will be measured for each member and in summary of all members reviewed. Measures of claims error incidence are (1) percent of units paid without service delivery documentation in the period and (2) percent of units paid in excess of authorized units in the period.
Discovery Method: For the provider financial audit, members are selected at random for the programmatic review. All claims for services delivered to them over a one quarter period are reviewed.
Frequency: Annually
Entity Responsible for Reviewing Findings: LTCWO Provider Audit Team
Communication: Report of financial audit to provider includes findings and recommendations/requirements for plan of correction/improvement of provider business process, if any. Prevalence of provider claims errors from the initial review may lead to additional sampling. If the audit detects a pattern of inappropriate billing, a referral is made to Program Integrity and Accountability for review and further investigation of the providers billing practices.

(d) OHCA Program Integrity and Accountability is responsible for conducting financial audits.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**
      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Percentage of service claims paid that were submitted for members who were enrolled in the waiver on the date that the service was delivered. Denominator: Paid claims Numerator: Paid claims for members enrolled in the waiver

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number of claims paid in accordance with waiver reimbursement methodology. Denominator: Paid claims Numerator: Paid claims adjudicated according to waiver reimbursement methodology.

Data Source (Select one):

Other
If 'Other' is selected, specify:
MMIS/DSS Query, Provider Audits

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percentage of payment errors remediated in accordance with OHCA policy following error identification through provider financial audits
Denominator: Payment errors identified Numerator: Number of payment errors remediated in accordance with OHCA policy

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number of denied waiver claims 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. Denominator: Denied claims for approved waiver Numerator: Claims denied based on service plan authorization edit checks

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

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

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

The OHCA State Plan Amendment Rate Committee (SPARC) is responsible for reviewing and setting all service rates for Medicaid services. Rates are given final consideration and approval by the OHCA Board.

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

1) Method One – Utilizing the fixed and uniform Medicaid rate: When a waiver service is similar or the same as a Medicaid service for which a fee schedule has been established, the current Medicaid rate is utilized. Waiver Services provider payment rates that utilize the Medicaid rate include the following:
a) Facility Based Respite Care: Reimbursement for this service is made at the current daily nursing facility rate.
b) Personal Care Services: Payment is made at the rate established for State Plan Personal Care services.
c) Respite in the Home: As this service is the equivalent of State Plan Personal Care Services but is designed to temporarily relieve the caregiver, the service is named Respite. Payment is made at the rate established for State Plan Personal Care services.
d) Prescription Drugs: Payment is made at the rate established for drugs paid for under the State Plan.
e) Therapy Services: Payment is made at the rate established for therapy services paid for under the State Plan.
f) Private Duty Nursing: Payment is made at the rate established for private duty nursing paid for under the State

Plan.
g) Skilled Nursing: Payment is made at the rate established for skilled nursing paid for under the State Plan.

2) Method Two -Utilizing the fixed and uniform waiver rate. Medically Fragile waiver services set by fixed, uniform rate setting are:
i) Case Management
ii) Home Delivered Meals
iii) Advanced Supportive/Restorative Assistance
iv) Hospice Care
v) Institutional Transition Services

The process used for establishing a Fixed and Uniform Rate is discussed below: Title 74 of the Oklahoma Statutes provides a methodology for setting fixed and uniform rates.
a) Determination of need for a fixed and uniform rate
i) New: A new service is developed, or
ii) Existing Service: Feedback from providers, members, or the general public indicates that the existing rate is not sufficient to ensure access to an existing service.
b) Preparation of a Rates and Standards Brief:
i) Preparation: Staff prepares a position paper that at a minimum includes a description of the service, the payment history including rates and utilization, the methodology utilized to arrive at the proposed rate, and a description of the funding source.
ii) Public Hearing: A public hearing notice is prepared and a hearing is scheduled.
iii) Oklahoma Office of Central Services: Copies of the public hearing notice, the Rates and Standards Brief and any other pertinent data is delivered to the Oklahoma Office of Central Services at least 30 days before the date of the public hearing. The Director of the Department of Central Services shall communication 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 State Plan Amendment Rate Committee of the Oklahoma Health Care Authority. The committee is comprised of staff from the OHCA and the Department of Human Services (DHS).
ii) Public comment: All attendees of the public hearing are offered an opportunity to voice their opposition or approval of the proposed rates. All comments become part of the permanent minutes of the hearing.
e) Final Approval: The rate is then scheduled for consideration and approval by the Board of Directors of the OHCA prior to implementation.
f) Institutional Transition Services vary depending on the location, provider and member needs.

The rate setting methodology for personal care, respite and advanced supportive/restorative process was most recently reviewed in September 2012. A rate proposal for State Plan Personal Care, ADvantage Waiver Personal Care, ADvantage Waiver Respite and ADvantage Advanced Supportive Restorative Assistance services was presented following the public processes outlined above. The methodology was not changed; however, the rate brief indicated that the rate increase from $3.63 to $3.69 per 15-minute unit was necessary to ensure access to care. The rates were requested, based on data collected from providers, to assure that access to personal care and related services are available to members requiring services and so that providers would have the ability to recruit and retain staff. The rate increase was proposed for implementation November 1, 2012. The former rate of $3.60 was effective September 1, 2006.

The rate setting methodology for case management was revised in 2002 based on a study of ADvantage case management service delivery. ADvantage conducted an experience-based time and resource study of direct case management of ADvantage consumers including adminstrative overhead such as supervision, utilities and telecommunications, facility rental, drive-time and other factors. Further, an analysis of time and dollar relationship to consumer ADLs, health and safety needs and other characteristics including county of residence to determine predictors of increased time and dollar case management resource utilization requirements was considered.

The rate setting methodology for home delivered meals is based on the average statewide cost of a meal under the Older Americans Act, reviewed and monitored by OKDHS Aging Services Division.

The rate setting methodology for hospice was established in October 2000 and was based on the average hospice rate

using Medicare rates for Oklahoma County, Tulsa County and the rest of the state. This amount was $87.10.

3) Method Three -Utilizing the current Medicare Rate: When the waiver service mirrors an existing Medicare service the current Medicare rate is utilized.

4) Method Four – Utilizing Individual Rates: Certain services because of their variables do not lend themselves to a fixed and uniform rate. Payment for these services is made on an individual basis following a uniform process approved by the Medicaid Agency. Services that are reimbursed utilizing an individual rate include:
a) Environmental Modifications: Methodology for these rates varies for different providers according to actual provider specialty. Providers may include Architects; Electricians; Engineers; Mechanical Contractors; Plumbers; Remodelers and Builders. Further, each required environmental modification is different. For example, ramps costs (due to the initial conditions of the home and yard) differ according to such variables as the length of the ramp, types of rails, and strength of the ramp needed if, for instance the member has an electric wheelchair.
b) Member-Directed Personal Care and Advanced Supportive/Restorative Assistance: Methodology for these rates includes an analysis of the comparable payments to agencies. A range of payments per hour is calculated for member consideration when hiring the member-directed personal or advanced care provider. This provides the member the flexibility as employer to pay different salaries to different workers within programmed defined limits.
c) Member-Directed Respite in the home: Methodology for these rates includes an analysis of the comparable payments to agencies for furnishing respite in the home. A range of payments per hour is calculated for member consideration when hiring the member-directed respite provider.
d) Personal Emergency Response Systems vary depending on the location and the provider.
e) Specialized Medical Equipment and Supplies are authorized by selecting the best bid from among a minimum of three, except for incontinence supplies. Incontinence supplies are reimbursed based on fixed rates that were established based on a study of Oklahoma and 24 other states' payments and providers' costs.
f) Self Directed Goods and Services - vary depending on the goods and services needed by the member.

Waiver members are informed about payment rates for services as the service plan is developed in a participant-centered manner with the member and designated representatives Each service plan covers one year of services, including the informal supports, and contains a summary of projected costs. The approved plan is distributed to the case manager, who in turn gives the approved plan to the waiver member. If a plan is amended due to changes in the member's goals or needs, the revised plan also includes all projected costs and payment rates.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Provider claims for waiver services are filed directly with the OHCA fiscal agent, Hewlett Packard (HP). Claims are adjudicated through Oklahoma's CMS-certified MMIS. All waiver services require prior authorization. Prior authorizations are generated from the waiver member's individual treatment plan. The prior authorization is in the MMIS. All transactions are HIPAA compliant and secure.

Appendix I: Financial Accountability

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

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

- [ ] **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

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

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Claims for waiver services are processed by Oklahoma's CMS-certified MMIS and are subject to all validation procedures included in the MMIS. This ensures that payments are made only when:

(a) All claims for waiver members are first validated for member eligibility according to data contained in the MMIS.

(b) All claims for waiver services must be matched to an active prior authorization. Prior authorizations are created from the waiver member's individual plan of care with provider of service, dates of authorization and units as specified in the service plan. Claims processing edits built into the MMIS deny claims payment if any of the following conditions are encountered:
• Date of service is outside member eligibility dates;
• Service provided is outside the benefit package for the waiver;
• Provider is not a qualified provider;
• Service is not prior authorized;
• Units are in excess of prior authorized;
• Date of service is outside prior authorization.

(c) All claims processed through the MMIS are subject to post-payment validation including, but not limited to Program Integrity and Accountability. When problems with service validation are identified on a post payment review, erroneous or invalidated claims are voided from the claims payment system and the previous payments are recouped from the provider. Provider audits (see Appendix I-1) review service delivery in comparison with claims and service plan authorization. If the provider audit detects a pattern of inappropriate billing, a referral is made to Program Integrity and Accountability for review and further investigation of the provider's billing practices.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

◉ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [x] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The FMS receives payment as the limited fiscal agent for self-directed services. Services that can be self-directed include: Personal Care, Advanced Supportive/Restorative Assistance and Respite. The limited Fiscal Agent performs the following functions:

1. Assists member in verifying support worker citizen status,

2. Collects and processes timesheets of support workers,

3. Processes payroll, withholding, filing and payment of applicable federal, state and local employment related taxes and insurance.

Limited Fiscal Agent services may include assistance with cognitive tasks, decision-making and specialized skills including assistance with Individual Budget Allocation Planning. In addition, according to the needs and desires of the member the FMS may provide orientation and training regarding employer responsibilities as well

employer information and management guidelines, materials, tools and staff consultant expertise to support and assist the member in successfully performing employer-related functions. OHCA's LTCWO Division is the direct contract monitor responsible for overseeing the operations of the limited fiscal agent.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ○ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ◉ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

Oklahoma does not restrict reassignment to any specific agency.

ii. **Organized Health Care Delivery System.** *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *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*:

- [x] **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:

☐ **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 members are subject to a co-payment on prescription drugs. Co-payments are not applied to other waiver services.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

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

Waiver Service	Charge
Prescribed Drugs	**Amount:** $0.00 for preferred generics $0.65 for cost of $0.00-$10.00 $1.20 for cost of $10.01-$25.00 $2.40 for cost of $25.01-$50.00 $3.50 for cost of $50.01 or more **Basis:**

	$0.00 for preferred generics $0.65 for prescriptions having a Medicaid allowable payment of $0.00-$10.00. $1.20 for prescriptions having a Medicaid allowable payment of $10.01-$25.00. $2.40 for prescriptions having a Medicaid allowable payment of $25.01-$50.00 and $3.50 for prescriptions having a Medicaid allowable of $50.01 or more. There is no co-payment for preferred generic medications.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

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

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

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

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the

Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital, Nursing Facility

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	47907.51	38557.00	86464.51	203066.00	25203.00	228269.00	141804.49
2	47907.51	39713.00	87620.51	209158.00	25959.00	235117.00	147496.49
3	41693.50	39677.00	81370.50	208970.00	25935.00	234905.00	153534.50
4	50245.59	40868.00	91113.59	215239.00	26713.00	241952.00	150838.41
5	48436.02	42094.00	90530.02	221696.00	27515.00	249211.00	158680.98

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Hospital	Level of Care: Nursing Facility
Year 1	90	12	78
Year 2	90	12	78
Year 3	110	15	95
Year 4	130	16	114
Year 5	155	17	138

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.

Average length of stay is estimated based on our experience in operating this program.

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 Derivation is based on our waiver experiences and expenditure data in operating the program thus

far. For some services, "average units used" and "average cost per unit" have been modified to reflect current reimbursement and expenditure levels. For this amendment, effective in the third waiver year, these have been reduced by three percent.

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' Derivation is based on our waiver experiences in operating this program, utilizing a three percent growh factor. For this amendment, effective in the third waiver year, figures have been reduced by three percent.

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 Derivation is based upon the weighted average of estimated institutional costs for skilled nursing facilities and hospitals serving persons who are medically fragile and/or technologically dependent. A more recent analysis of state fiscal year 2010 data is used for the base year and increased by three percent for future years. For this amendment, effective in the third waiver year, these have been reduced by three percent.

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 Derivation is based upon the weighted average of estimated costs of other non-institutional Title XIX services for persons who are in the skilled nursing facility or a hospital. A more recent analysis of state fiscal year 2010 data is used for the base year and increased by three percent for future years. For this amendment, effective in the third waiver year, figures have been reduced by three percent.

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
Case Management
Personal Care
Respite
Prescribed Drugs
Advanced Supportive/Restorative Assistance
Environmental Modifications
Home Delivered Meals
Hospice Care
Institutional Transition Services
Personal Emergency Response System (PERS)
Private Duty Nursing
Self-Directed Goods and Services (SD-GS)
Skilled Nursing
Specialized Medical Equipment and Supplies
Therapy Services: Respiratory
Therapy Services: Occupational
Therapy Services: Physical
Therapy Services: Speech

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
Case Management Total:						**2654775.00**
Case Management	15 min	90	2070.00	14.25	**2654775.00**	
Personal Care Total:						**69364.62**
Personal Care	15 min	36	482.00	3.69	**64028.88**	
Self-Directed Personal Care	15 min	3	482.00	3.69	**5335.74**	
Respite Total:						**14161.79**
Extended Respite	1 day	1	3.00	165.88	**497.64**	
Respite	15 min	4	307.00	3.69	**4531.32**	
Selfl-Directed Respite	15 min	1	307.00	3.69	**1132.83**	
Nursing Facility Based	1 day	4	16.00	125.00	**8000.00**	
Prescribed Drugs Total:						**36947.04**
Prescribed Drugs	per prescribed drug	52	9.30	76.40	**36947.04**	
Advanced Supportive/Restorative Assistance Total:						**68617.48**
Self-Directed Advanced Supportive/Restorative Assistance	15 min	3	596.00	3.97	**7098.36**	
Advanced Supportive/Restorative Assistance	15 min	26	596.00	3.97	**61519.12**	
Environmental Modifications Total:						**6400.00**
Environmental Modifications	per modification	4	1.00	1600.00	**6400.00**	
Home Delivered Meals Total:						**2342.40**
Home Delivered Meals	1 meal	16	30.00	4.88	**2342.40**	
Hospice Care Total:						**29060.40**
Hospice Care	1 day	4	61.00	119.10	**29060.40**	
Institutional Transition Services Total:						**1140.00**
Institutional Transition Services	15 min	4	20.00	14.25	**1140.00**	
Personal Emergency Response System (PERS) Total:						**913.13**
Personal Emergency Response System (PERS)	1 mo	9	3.32	30.56	**913.13**	

Private Duty Nursing Total:						**1305360.00**
Private Duty Nursing	15 min	40	5180.00	6.30	**1305360.00**	
Self-Directed Goods and Services (SD-GS) Total:						**945.00**
Self-Directed Goods and Services (SD-GS)	N/A	3	3.00	105.00	**945.00**	
Skilled Nursing Total:						**13284.00**
Skilled Nursing	15 min	60	16.40	13.50	**13284.00**	
Specialized Medical Equipment and Supplies Total:						**102525.00**
Specialized Medical Equipment and Supplies	per item	60	1367.00	1.25	**102525.00**	
Therapy Services: Respiratory Total:						**800.00**
Therapy Services: Respiratory	15 min	4	10.00	20.00	**800.00**	
Therapy Services: Occupational Total:						**2400.00**
Therapy Services: Occupational	15 min	4	30.00	20.00	**2400.00**	
Therapy Services: Physical Total:						**2320.00**
Therapy Services: Physical	15 min	4	29.00	20.00	**2320.00**	
Therapy Services: Speech Total:						**320.00**
Therapy Services: Speech	15 min	4	4.00	20.00	**320.00**	
GRAND TOTAL:						**4311675.86**
Total Estimated Unduplicated Participants:						**90**
Factor D (Divide total by number of participants):						**47907.51**
Average Length of Stay on the Waiver:						200

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
Case Management Total:						**2654775.00**
Case Management	15 min	90	2070.00	14.25	**2654775.00**	
Personal Care Total:						**69364.62**
Personal Care	15 min	36	482.00	3.69	**64028.88**	

Self-Directed Personal Care	15 min	3	482.00	3.69	**5335.74**	
Respite Total:						**14161.79**
Extended Respite	1 day	1	3.00	165.88	**497.64**	
Respite	15 min	4	307.00	3.69	**4531.32**	
Selfl-Directed Respite	15 min	1	307.00	3.69	**1132.83**	
Nursing Facility Based	1 day	4	16.00	125.00	**8000.00**	
Prescribed Drugs Total:						**36947.04**
Prescribed Drugs	per prescribed drug	52	9.30	76.40	**36947.04**	
Advanced Supportive/Restorative Assistance Total:						**68617.48**
Self-Directed Advanced Supportive/Restorative Assistance	15 min	3	596.00	3.97	**7098.36**	
Advanced Supportive/Restorative Assistance	15 min	26	596.00	3.97	**61519.12**	
Environmental Modifications Total:						**6400.00**
Environmental Modifications	per modification	4	1.00	1600.00	**6400.00**	
Home Delivered Meals Total:						**2342.40**
Home Delivered Meals	1 meal	16	30.00	4.88	**2342.40**	
Hospice Care Total:						**29060.40**
Hospice Care	1 day	4	61.00	119.10	**29060.40**	
Institutional Transition Services Total:						**1140.00**
Institutional Transition Services	15 min	4	20.00	14.25	**1140.00**	
Personal Emergency Response System (PERS) Total:						**913.13**
Personal Emergency Response System (PERS)	1 mo	9	3.32	30.56	**913.13**	
Private Duty Nursing Total:						**1305360.00**
Private Duty Nursing	15 min	40	5180.00	6.30	**1305360.00**	
Self-Directed Goods and Services (SD-GS) Total:						**945.00**
Self-Directed Goods and Services (SD-GS)	N/A	3	3.00	105.00	**945.00**	
Skilled Nursing Total:						**13284.00**
Skilled Nursing	15 min	60	16.40	13.50	**13284.00**	
Specialized Medical Equipment and Supplies Total:						**102525.00**
Specialized Medical Equipment and Supplies	per item	60	1367.00	1.25	**102525.00**	
Therapy Services: Respiratory Total:						**800.00**

Therapy Services: Respiratory	15 min	4	10.00	20.00	**800.00**	
Therapy Services: Occupational Total:						**2400.00**
Therapy Services: Occupational	15 min	4	30.00	20.00	**2400.00**	
Therapy Services: Physical Total:						**2320.00**
Therapy Services: Physical	15 min	4	29.00	20.00	**2320.00**	
Therapy Services: Speech Total:						**320.00**
Therapy Services: Speech	15 min	4	4.00	20.00	**320.00**	
GRAND TOTAL:						**4311675.86**
Total Estimated Unduplicated Participants:						**90**
Factor D (Divide total by number of participants):						**47907.51**
Average Length of Stay on the Waiver:						208

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
Case Management Total:						**2803525.20**
Case Management	15 min	98	2070.00	13.82	**2803525.20**	
Personal Care Total:						**93411.60**
Personal Care	15 min	48	482.00	3.80	**87916.80**	
Self-Directed Personal Care	15 min	3	482.00	3.80	**5494.80**	
Respite Total:						**18298.20**
Extended Respite	1 day	2	3.00	160.90	**965.40**	
Respite	15 min	6	307.00	3.80	**6999.60**	
Selfl-Directed Respite	15 min	2	307.00	3.80	**2333.20**	
Nursing Facility Based	1 day	4	16.00	125.00	**8000.00**	
Prescribed Drugs Total:						**55420.56**
Prescribed Drugs	per prescribed drug	78	9.30	76.40	**55420.56**	
Advanced Supportive/Restorative Assistance Total:						**97505.60**

Self-Directed Advanced Supportive/Restorative Assistance	15 min	4	596.00	4.09	**9750.56**	
Advanced Supportive/Restorative Assistance	15 min	36	596.00	4.09	**87755.04**	
Environmental Modifications Total:						**9600.00**
Environmental Modifications	per modification	6	1.00	1600.00	**9600.00**	
Home Delivered Meals Total:						**3405.60**
Home Delivered Meals	1 meal	24	30.00	4.73	**3405.60**	
Hospice Care Total:						**42283.98**
Hospice Care	1 day	6	61.00	115.53	**42283.98**	
Institutional Transition Services Total:						**1658.40**
Institutional Transition Services	15 min	6	20.00	13.82	**1658.40**	
Personal Emergency Response System (PERS) Total:						**1318.97**
Personal Emergency Response System (PERS)	1 mo	13	3.32	30.56	**1318.97**	
Private Duty Nursing Total:						**1265992.00**
Private Duty Nursing	15 min	40	5180.00	6.11	**1265992.00**	
Self-Directed Goods and Services (SD-GS) Total:						**1260.00**
Self-Directed Goods and Services (SD-GS)	N/A	4	3.00	105.00	**1260.00**	
Skilled Nursing Total:						**19320.84**
Skilled Nursing	15 min	90	16.40	13.09	**19320.84**	
Specialized Medical Equipment and Supplies Total:						**153787.50**
Specialized Medical Equipment and Supplies	per item	90	1367.00	1.25	**153787.50**	
Therapy Services: Respiratory Total:						**1164.00**
Therapy Services: Respiratory	15 min	6	10.00	19.40	**1164.00**	
Therapy Services: Occupational Total:						**8730.00**
Therapy Services: Occupational	15 min	15	30.00	19.40	**8730.00**	
Therapy Services: Physical Total:						**8439.00**
Therapy Services: Physical	15 min	15	29.00	19.40	**8439.00**	
Therapy Services: Speech Total:						**1164.00**
Therapy Services: Speech	15 min	15	4.00	19.40	**1164.00**	

GRAND TOTAL:	**4586285.45**
Total Estimated Unduplicated Participants:	**110**
Factor D (Divide total by number of participants):	**41693.50**
Average Length of Stay on the Waiver:	212

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
Case Management Total:						**3718962.00**
Case Management	15 min	130	2070.00	13.82	**3718962.00**	
Personal Care Total:						**109896.00**
Personal Care	15 min	55	482.00	3.80	**100738.00**	
Self-Directed Personal Care	15 min	5	482.00	3.80	**9158.00**	
Respite Total:						**27596.80**
Extended Respite	1 day	4	3.00	160.90	**1930.80**	
Respite	15 min	7	307.00	3.80	**8166.20**	
Selfl-Directed Respite	15 min	3	307.00	3.80	**3499.80**	
Nursing Facility Based	1 day	7	16.00	125.00	**14000.00**	
Prescribed Drugs Total:						**63946.80**
Prescribed Drugs	per prescribed drug	90	9.30	76.40	**63946.80**	
Advanced Supportive/Restorative Assistance Total:						**114569.08**
Self-Directed Advanced Supportive/Restorative Assistance	15 min	5	596.00	4.09	**12188.20**	
Advanced Supportive/Restorative Assistance	15 min	42	596.00	4.09	**102380.88**	
Environmental Modifications Total:						**11200.00**
Environmental Modifications	per modification	7	1.00	1600.00	**11200.00**	
Home Delivered Meals Total:						**3973.20**
Home Delivered Meals	1 meal	28	30.00	4.73	**3973.20**	
Hospice Care Total:						**49331.31**
Hospice Care	1 day	7	61.00	115.53	**49331.31**	
Institutional Transition Services Total:						**1995.00**
Institutional Transition Services	15 min	7	20.00	14.25	**1995.00**	

Personal Emergency Response System (PERS) Total:						**1521.89**
Personal Emergency Response System (PERS)	1 mo	15	3.32	30.56	**1521.89**	
Private Duty Nursing Total:						**2215486.00**
Private Duty Nursing	15 min	70	5180.00	6.11	**2215486.00**	
Self-Directed Goods and Services (SD-GS) Total:						**1575.00**
Self-Directed Goods and Services (SD-GS)	N/A	5	3.00	105.00	**1575.00**	
Skilled Nursing Total:						**22540.98**
Skilled Nursing	15 min	105	16.40	13.09	**22540.98**	
Specialized Medical Equipment and Supplies Total:						**179418.75**
Specialized Medical Equipment and Supplies	per item	105	1367.00	1.25	**179418.75**	
Therapy Services: Respiratory Total:						**1358.00**
Therapy Services: Respiratory	15 min	7	10.00	19.40	**1358.00**	
Therapy Services: Occupational Total:						**4074.00**
Therapy Services: Occupational	15 min	7	30.00	19.40	**4074.00**	
Therapy Services: Physical Total:						**3938.20**
Therapy Services: Physical	15 min	7	29.00	19.40	**3938.20**	
Therapy Services: Speech Total:						**543.20**
Therapy Services: Speech	15 min	7	4.00	19.40	**543.20**	
GRAND TOTAL:						**6531926.21**
Total Estimated Unduplicated Participants:						**130**
Factor D (Divide total by number of participants):						**50245.59**
Average Length of Stay on the Waiver:						214

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
Case Management Total:						**4291110.00**
Case Management	15 min	150	2070.00	13.82	**4291110.00**	

Personal Care Total:						**126380.40**
Personal Care	15 min	64	482.00	3.80	**117222.40**	
Self-Directed Personal Care	15 min	5	482.00	3.80	**9158.00**	
Respite Total:						**33579.30**
Extended Respite	1 day	5	3.00	160.90	**2413.50**	
Respite	15 min	8	307.00	3.80	**9332.80**	
Selfl-Directed Respite	15 min	5	307.00	3.80	**5833.00**	
Nursing Facility Based	1 day	8	16.00	125.00	**16000.00**	
Prescribed Drugs Total:						**73894.08**
Prescribed Drugs	per prescribed drug	104	9.30	76.40	**73894.08**	
Advanced Supportive/Restorative Assistance Total:						**129194.92**
Self-Directed Advanced Supportive/Restorative Assistance	15 min	5	596.00	4.09	**12188.20**	
Advanced Supportive/Restorative Assistance	15 min	48	596.00	4.09	**117006.72**	
Environmental Modifications Total:						**12800.00**
Environmental Modifications	per modification	8	1.00	1600.00	**12800.00**	
Home Delivered Meals Total:						**4540.80**
Home Delivered Meals	1 meal	32	30.00	4.73	**4540.80**	
Hospice Care Total:						**56378.64**
Hospice Care	1 day	8	61.00	115.53	**56378.64**	
Institutional Transition Services Total:						**2280.00**
Institutional Transition Services	15 min	8	20.00	14.25	**2280.00**	
Personal Emergency Response System (PERS) Total:						**1724.81**
Personal Emergency Response System (PERS)	1 mo	17	3.32	30.56	**1724.81**	
Private Duty Nursing Total:						**2531984.00**
Private Duty Nursing	15 min	80	5180.00	6.11	**2531984.00**	
Self-Directed Goods and Services (SD-GS) Total:						**1575.00**
Self-Directed Goods and Services (SD-GS)	N/A	5	3.00	105.00	**1575.00**	
Skilled Nursing Total:						**25761.12**
Skilled Nursing	15 min	120	16.40	13.09	**25761.12**	
Specialized Medical Equipment and Supplies Total:						**205050.00**

Specialized Medical Equipment and Supplies	per item	120	1367.00	1.25	**205050.00**	
Therapy Services: Respiratory Total:						**1552.00**
Therapy Services: Respiratory	15 min	8	10.00	19.40	**1552.00**	
Therapy Services: Occupational Total:						**4656.00**
Therapy Services: Occupational	15 min	8	30.00	19.40	**4656.00**	
Therapy Services: Physical Total:						**4500.80**
Therapy Services: Physical	15 min	8	29.00	19.40	**4500.80**	
Therapy Services: Speech Total:						**620.80**
Therapy Services: Speech	15 min	8	4.00	19.40	**620.80**	

GRAND TOTAL:	**7507582.67**
Total Estimated Unduplicated Participants:	**155**
Factor D (Divide total by number of participants):	**48436.02**
Average Length of Stay on the Waiver:	216